Senate

General Assembly

File No. 574

January Session, 2017

Substitute Senate Bill No. 795

Senate, April 13, 2017

The Committee on Public Health reported through SEN. GERRATANA of the 6th Dist. and SEN. SOMERS of the 18th Dist., Chairpersons of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT ESTABLISHING THE OFFICE OF HEALTH STRATEGY AND IMPROVING THE CERTIFICATE OF NEED PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2018*) (a) There is established an Office of Health Strategy, which shall be within the Department of Public Health for administrative purposes only. The department head of said office shall be the executive director of the Office of Health Strategy, who shall be appointed by the Governor in accordance with the provisions of sections 4-5 to 4-8, inclusive, of the general statutes, with the powers and duties therein prescribed.

(b) The Office of Health Strategy shall be responsible for the following:

(1) Developing and implementing a comprehensive and cohesive health care vision for the state, including, but not limited to, a coordinated state health care cost containment strategy;

(2) Directing and overseeing (A) the all-payers claim database program established pursuant to section 38-1091 of the general statutes, and (B) the State Innovation Model Initiative and related successor initiatives;

(3) Coordinating the state's health information technology initiatives;

(4) Directing and overseeing the Office of Health Care Access and all of its duties and responsibilities as set forth in chapter 368z of the general statutes; and

(5) Convening forums and meetings with state government and external stakeholders, including, but not limited to, the Connecticut Health Insurance Exchange, to discuss health care issues designed to develop effective health care cost and quality strategies.

(c) The Office of Health Strategy shall constitute a successor, in accordance with the provisions of sections 4-38d, 4-38e and 4-39 of the general statutes, to the functions, powers and duties of the following:

(1) The Connecticut Health Insurance Exchange, established pursuant to section 38a-1081 of the general statutes, relating to the administration of the all-payer claims database pursuant to section 38a-1091 of the general statutes; and

(2) The Office of the Lieutenant Governor, relating to the (A) development of a chronic disease plan pursuant to section 19a-6q of the general statutes, (B) housing, chairing and staffing of the Health Care Cabinet pursuant to section 19a-725 of the general statutes, and (C) (i) appointment of the health information technology officer pursuant to section 19a-755 of the general statutes, and (ii) oversight of the duties of such health information technology officer as set forth in sections 17b-59, 17b-59a and 17b-59f of the general statutes, as amended by this act.

(d) Any order or regulation of the entities listed in subdivisions (1) and (2) of subsection (c) of this section that is in force on July 1, 2018,

shall continue in force and effect as an order or regulation until amended, repealed or superseded pursuant to law.

Sec. 2. Section 19a-630 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

As used in this chapter, unless the context otherwise requires:

(1) "Access" means the availability of services to a population who needs such services and the ability to obtain such services when considering the location, reasonable available public or private transportation options, hours of operation and language or cultural considerations for the population seeking such services.

(2) "Affected community" means a municipality where a health care facility is physically located or a municipality whose inhabitants are regularly served by a health care facility.

[(1)**]** (3) "Affiliate" means a person, entity or organization controlling, controlled by or under common control with another person, entity or organization. Affiliate does not include a medical foundation organized under chapter 594b.

[(2)**]** (4) "Applicant" means any person or health care facility that applies for a certificate of need pursuant to section 19a-639a, as amended by this act.

[(3) "Bed capacity" means the total number of inpatient beds in a facility licensed by the Department of Public Health under sections 19a-490 to 19a-503, inclusive.

(4) "Capital expenditure" means an expenditure that under generally accepted accounting principles consistently applied is not properly chargeable as an expense of operation or maintenance and includes acquisition by purchase, transfer, lease or comparable arrangement, or through donation, if the expenditure would have been considered a capital expenditure had the acquisition been by purchase.**]**

(5) "Behavioral health facility" means any facility that provides mental health services to persons eighteen years of age or older or substance use disorder services to persons of any age in an outpatient treatment or residential setting to ameliorate mental, emotional, behavioral or substance use disorder issues, including, but not limited to, private freestanding mental health day treatment facilities.

[(5)**]** (6) "Certificate of need" means a certificate issued by the office.

[(6)**]** (7) "Days" means calendar days.

[(7)**]** (8) "Deputy commissioner" means the deputy commissioner of Public Health who oversees the Office of Health Care Access division of the Department of Public Health.

[(8)**]** (9) "Commissioner" means the Commissioner of Public Health.

[(9)**]** (10) "Free clinic" means a private, nonprofit community-based organization that provides medical, dental, pharmaceutical or mental health services at reduced cost or no cost to low-income, uninsured and underinsured individuals.

(11) "Freestanding emergency department" means an emergency department that is listed as a satellite location and held out to the public by name, posted signs, advertising or other means as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

(12) "Health care services" means care and services of a medical, mental health, substance use disorder treatment, surgical, psychiatric, therapeutic, diagnostic or rehabilitative nature, including, but not limited to, inpatient and outpatient acute hospital care and services. For purposes of this subdivision, "inpatient" means a patient has been formally admitted to a hospital on the order of a physician, and "outpatient" means without a requirement that a patient be formally admitted to a hospital to receive care.

(13) "Hospital" means a health care facility or institution licensed by

the Department of Public Health to provide both inpatient and outpatient services as one of the following: (A) A general hospital licensed by the Department of Public Health, including, but not limited to, John Dempsey Hospital of The University of Connecticut Health Center, as a short-term, acute care general or children's hospital; or (B) a specialty hospital that provides chronic disease treatment, maternity, inpatient psychiatric, rehabilitation or hospice services.

(14) "Hospital system" means: (A) A parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance or membership; or (B) a hospital and any entity affiliated with such hospital through ownership, governance or membership.

[(10)**]** (15) "Large group practice" means eight or more full-time equivalent physicians, legally organized in a partnership, professional corporation, limited liability company formed to render professional services, medical foundation, not-for-profit corporation, faculty practice plan or other similar entity (A) in which each physician who is a member of the group provides substantially the full range of services that the physician routinely provides, including, but not limited to, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel; (B) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group practice and amounts so received are treated as receipts of the group; or (C) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group. An entity that otherwise meets the definition of group practice under this section shall be considered a group practice although its shareholders, partners or owners of the group practice include single-physician professional corporations, limited liability companies formed to render professional services or other entities in which beneficial owners are individual physicians.

[(11)**]** (16) "Health care facility" means (A) hospitals; **[**licensed by the Department of Public Health under chapter 368v; (B) specialty hospitals; (C)**]** (B) freestanding emergency departments; **[**(D)**]** (C) outpatient surgical facilities; **[**, as defined in section 19a-493b and licensed under chapter 368v; (E)**]** (D) a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended; **[**(F) a central service facility; (G) mental health facilities; (H) substance abuse treatment facilities; and (I)**]** (E) behavioral health facilities; and (F) any other facility requiring certificate of need review pursuant to subsection (a) of section 19a-638, as amended by this act. "Health care facility" includes any parent company, subsidiary, affiliate or joint venture, or any combination thereof, of any such facility.

[(12) "Nonhospital based" means located at a site other than the main campus of the hospital.**]**

(17) "New hospital" means a hospital as it exists after the approval of an agreement pursuant to section 19a-486b, as amended by this act, or a certificate of need application for a transfer of ownership of a hospital;

[(13)**]** (18) "Office" means the Office of Health Care Access division within the Department of Public Health.

(19) "Outpatient surgical facility" has the same meaning as provided in section 19a-493b.

[(14)**]** (20) "Person" means any individual, partnership, corporation, limited liability company, association, governmental subdivision, agency or public or private organization of any character, but does not include the agency conducting the proceeding.

[(15)**]** (21) "Physician" has the same meaning as provided in section 20-13a.

(22) "Purchaser" means (A) a person who is acquiring or has

acquired any assets of a hospital through a transfer of ownership of a hospital; or (B) a hospital or hospital system that is acquiring or has acquired any assets of a health care facility other than a hospital, or a large group practice through a transfer of ownership.

(23) "Quality" means the degree to which health care services for individuals or populations increase the likelihood of desired health outcomes and are consistent with established professional knowledge, standards and guidelines.

(24) "Relocation" means the movement of a health care facility from its established location to a different location.

(25) "Reduction" means any modification to a health care service by a hospital or hospital system that, independently or in conjunction with other modifications or changes, results in a fifty per cent or greater decrease in the availability of the health care service offered by such hospital or hospital system or reduces the service area covered by such hospital or hospital system.

(26) "Termination" means the elimination by a health care facility of a health care service, but does not include a temporary suspension of health care services lasting six months or less.

(27) "Transacting party" means a purchaser and any person who is a party to a proposed agreement for (A) transfer of ownership of a hospital; or (B) transfer of ownership of a health care facility or large group practice to a hospital or hospital system.

(28) "Transfer" means to sell, lease, exchange, option, convey, give or otherwise dispose of, including, but not limited to, transfer by way of merger or joint venture not in the ordinary course of business.

[(16)**]** (29) "Transfer of ownership" means a transfer that impacts or changes the governance or controlling body of a health care facility, institution or large group practice, including, but not limited to, all affiliations, mergers or any sale or transfer of net assets of a health care facility.

Sec. 3. Section 19a-634 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

[(a) The Office of Health Care Access shall conduct, on a biennial basis, a state-wide health care facility utilization study. Such study may include an assessment of: (1) Current availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) geographic areas and subpopulations that may be underserved or have reduced access to specific types of health care services; and (3) other factors that the office deems pertinent to health care facility utilization. Not later than June thirtieth of the year in which the biennial study is conducted, the Commissioner of Public Health shall report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services on the findings of the study. Such report may also include the office's recommendations for addressing identified gaps in the provision of health care services and recommendations concerning a lack of access to health care services.

(b) The office,**]** (a) The Office of Health Care Access, in consultation with such other state agencies as the Commissioner of Public Health deems appropriate, shall establish and maintain a state-wide health care facilities and services plan. Such plan **[**may**]** shall, within available appropriations, include, but not be limited to: (1) **[**An**]** A state-wide health care facility utilization study, consisting of an assessment of the availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) an evaluation of the unmet needs of persons at risk and vulnerable populations as determined by the commissioner; (3) the identification of geographic areas that may be underserved or have reduced access to specific types of health care services; (4) a projection of future demand for health care services and the impact that technology may have on the demand, capacity or need for such services; (5) the identification of clinical best practices, as applicable to certificate of need requirements under section 19a-638, as amended by

this act; and [(4)] (6) recommendations for [the expansion, reduction or modification of health care facilities or services] (A) addressing identified unmet health care needs, (B) integrating and aligning clinical best practices into licensure requirements or other ongoing monitoring efforts by the department to enhance quality of care, and (C) any improvements or changes necessary to the office's programs, including the certificate of need process, in order to promote health equity. In the development of the plan, the office shall consider the recommendations of any advisory bodies which may be established by the commissioner. The commissioner may also incorporate the recommendations of authoritative organizations whose mission is to promote policies based on best practices or evidence-based research. The commissioner, in consultation with hospital, hospital system and other health care facility representatives, shall develop a process that encourages [hospitals] such entities to incorporate the state-wide health care facilities and services plan into [hospital] long-range planning and shall facilitate communication between appropriate state agencies concerning innovations or changes that may affect future health planning. The office shall update the state-wide health care facilities and services plan not less than once every two years.

[(c)] (b) For purposes of [conducting the state-wide health care facility utilization study and] preparing the state-wide health care facilities and services plan, the office shall establish and maintain an inventory of all health care facilities, the equipment identified in [subdivisions (9) and (10)] subdivision (7) of subsection (a) of section 19a-638, as amended by this act, and services in the state, including health care facilities that are exempt from certificate of need requirements under subsection (b) of section 19a-638, as amended by this act. The office [shall develop] may utilize an inventory questionnaire to obtain the following information: (1) The name and location of the facility; (2) the type of facility; (3) the hours of operation; (4) the type of services provided at that location; and (5) the total number of clients, treatments, patient visits, procedures performed or scans performed in a calendar year. The inventory shall be completed [biennially] every three years by health care facilities and providers

and such health care facilities and providers shall not be required to provide patient specific or financial data.

Sec. 4. Section 19a-637 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

The office shall promote effective health planning in the state. In carrying out its assigned duties, the office shall promote the provision of quality health care in a manner that ensures access for all state residents to cost-effective services so as to **[**avoid duplication of health services and**]** improve the availability and financial stability of health care services throughout the state.

Sec. 5. Section 19a-638 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) A certificate of need issued by the office shall be required for:

(1) The establishment of a new **[**health care facility**]** hospital, freestanding emergency department or outpatient surgical facility, except as provided in section 19a-639e, as amended by this act;

(2) A transfer of ownership of a health care facility;

(3) A transfer of ownership of a hospital to another hospital, hospital system or other entity;

[(3)**]** (4) A transfer of ownership of a large group practice to any entity other than a (A) physician, or (B) group of two or more physicians, legally organized in a partnership, professional corporation or limited liability company formed to render professional services and not employed by or an affiliate of any hospital, medical foundation, insurance company or other similar entity;

[(4) The establishment of a freestanding emergency department;**]**

(5) The termination of an emergency department or inpatient or outpatient services offered by a hospital, **[**including, but not limited to, the termination by a short-term acute care general hospital or

children's hospital of inpatient and outpatient mental health and substance abuse services**]** hospital system or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended from time to time, except (A) the termination of services due to insufficient patient volume or lack of available practitioners to support the effective delivery of care that is subject to the termination request process set forth in section 19a-639e, as amended by this act, and (B) the termination of services for which the Department of Public health has requested the hospital to relinquish its license;

[(6) The establishment of an outpatient surgical facility, as defined in section 19a-493b, or as established by a short-term acute care general hospital;

(7) The termination of surgical services by an outpatient surgical facility, as defined in section 19a-493b, or a facility that provides outpatient surgical services as part of the outpatient surgery department of a short-term acute care general hospital, provided termination of outpatient surgical services due to (A) insufficient patient volume, or (B) the termination of any subspecialty surgical service, shall not require certificate of need approval;

(8) The termination of an emergency department by a short-term acute care general hospital;**]**

[(9)**]** (6) The establishment of cardiac services, including inpatient and outpatient cardiac catheterization, interventional cardiology and cardiovascular surgery; and

[(10)**]** (7) The acquisition of scanners that utilize imaging techniques, including, but not limited to, computed tomography, **[**scanners,**]** magnetic resonance imaging, **[**scanners,**]** positron emission tomography, **[**scanners or**]** positron emission tomography-computed tomography **[**scanners,**]** or single-photon emission computed tomography by any person, physician, provider **[**, short-term acute

care general hospital or children's hospital, except (A) as provided for in subdivision (22) of subsection (b) of this section, and (B) a certificate of need issued by the office shall not be required where such scanner is a replacement for a scanner that was previously acquired through certificate of need approval or a certificate of need determination;**]** or hospital that filed a request pursuant to subsection (b) of section 19a-639e, as amended by this act, and did not sufficiently demonstrate to the satisfaction of the office that methods will be employed to minimize the practice of patient referrals in which the referring provider stands to financially gain from such referral and that Medicaid recipients and indigent persons will have access to services provided utilizing the acquired equipment.

[(11) The acquisition of nonhospital based linear accelerators;

(12) An increase in the licensed bed capacity of a health care facility;

(13) The acquisition of equipment utilizing technology that has not previously been utilized in the state;

(14) An increase of two or more operating rooms within any three-year period, commencing on and after October 1, 2010, by an outpatient surgical facility, as defined in section 19a-493b, or by a short-term acute care general hospital; and

(15) The termination of inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended.**]**

(b) A certificate of need shall not be required for:

(1) Health care facilities owned and operated by the federal government;

(2) The establishment of offices by a licensed private practitioner, whether for individual or group practice, except when a certificate of need is required in accordance with the requirements of section 19a-

493b or subdivision [(3), (10) or (11)] (4) or (7) of subsection (a) of this section;

(3) A health care facility operated by a religious group that exclusively relies upon spiritual means through prayer for healing;

(4) Residential care homes, nursing homes and rest homes, as defined in subsection (c) of section 19a-490;

(5) An assisted living services agency, as defined in section 19a-490;

(6) Home health agencies, as defined in section 19a-490;

(7) Hospice services, as described in section 19a-122b;

(8) Outpatient rehabilitation facilities;

(9) Outpatient chronic dialysis services;

(10) Transplant services;

(11) Free clinics, as defined in section 19a-630, as amended by this act;

(12) School-based health centers and expanded school health sites, as such terms are defined in section 19a-6r, community health centers, as defined in section 19a-490a, not-for-profit outpatient clinics licensed in accordance with the provisions of chapter 368v and federally qualified health centers;

(13) A program licensed or funded by the Department of Children and Families, provided such program is not a psychiatric residential treatment facility;

(14) Any nonprofit facility, institution or provider that has a contract with, or is certified or licensed to provide a service for, a state agency or department for a service that would otherwise require a certificate of need. The provisions of this subdivision shall not apply to a short-term acute care general hospital or children's hospital, or a hospital or

other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended;

(15) A health care facility operated by a nonprofit educational institution exclusively for students, faculty and staff of such institution and their dependents;

(16) An outpatient clinic or program operated exclusively by or contracted to be operated exclusively by a municipality, municipal agency, municipal board of education or a health district, as described in section 19a-241;

(17) A residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disabilities;

(18) Replacement of existing imaging equipment with similar imaging equipment if such equipment was acquired through certificate of need approval or a certificate of need determination, provided a health care facility, provider, physician or person notifies the office of the date on which the equipment is replaced and the disposition of the replaced equipment;

(19) Acquisition of cone-beam dental imaging equipment that is to be used exclusively by a dentist licensed pursuant to chapter 379; or

[(20) The partial or total elimination of services provided by an outpatient surgical facility, as defined in section 19a-493b, except as provided in subdivision (6) of subsection (a) of this section and section 19a-639e;

(21) The termination of services for which the Department of Public Health has requested the facility to relinquish its license; or**]**

[(22)**]** (20) Acquisition of any equipment by any person that is to be used exclusively for scientific research that is not conducted on

humans.

(c) **[**(1)**]** Any person, health care facility or institution that is unsure whether a certificate of need is required under this section **[**, or (2) any health care facility that proposes to relocate pursuant to section 19a-639c**]** shall send a letter to the office that describes the project and requests that the office make a determination as to whether a certificate of need is required. **[**In the case of a relocation of a health care facility, the letter shall include information described in section 19a-639c.**]** A person, health care facility or institution making such request shall provide the office with any information the office requests as part of its determination process.

(d) The Commissioner of Public Health may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner holds a public hearing prior to implementing the policies and procedures and prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted. **[**Final regulations shall be adopted by December 31, 2011.**]**

Sec. 6. Section 19a-639 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) In any deliberations involving a certificate of need application filed pursuant to subdivisions (1), (2), (4), (6) and (7) of subsection (a) of section 19a-638, as amended by this act, the office shall take into consideration and make written findings concerning each of the following guidelines and principles, as applicable:

(1) Whether the **[**proposed project**]** proposal is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;

(2) [The relationship of the proposed project to] Whether the proposal is aligned with the state-wide health care facilities and services plan established under section 19a-634, as amended by this act, including whether the proposal will serve individuals in geographic areas that are underserved or have reduced access to specific types of health care services;

[(3) Whether there is a clear public need for the health care facility or services proposed by the applicant;

(4) Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;]

[(5)] (3) Whether the applicant has satisfactorily demonstrated [how] that the proposal will not adversely impact the health care market in the state, will improve quality, accessibility and cost effectiveness of health care delivery in the region [, including, but not limited to, provision of or any change in the access to services for Medicaid recipients and indigent persons] and, as applicable to the acquisition of scanners, will minimize the practice of patient referrals in which the referring practitioner will stand to financially gain from such referral;

[(6)] (4) The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including [, but not limited to,] whether the applicant has satisfactorily demonstrated how the proposal will provide access to services by Medicaid recipients and indigent persons; and

[(7) Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;

(8) The utilization of existing health care facilities and health care services in the service area of the applicant;

(9) Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;

(10) Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;**]**

[(11)**]** (5) Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the **[**diversity of health care providers and**]** patient choice of providers in the geographic region. **[**; and**]**

[(12) Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care.

(b) In deliberations as described in subsection (a) of this section, there shall be a presumption in favor of approving the certificate of need application for a transfer of ownership of a large group practice, as described in subdivision (3) of subsection (a) of section 19a-638, when an offer was made in response to a request for proposal or similar voluntary offer for sale.

(c) The office, as it deems necessary, may revise or supplement the guidelines and principles through regulation prescribed in subsection (a) of this section.

(d) (1) For purposes of this subsection and subsection (e) of this section:

(A) "Affected community" means a municipality where a hospital is physically located or a municipality whose inhabitants are regularly served by a hospital;

(B) "Hospital" has the same meaning as provided in section 19a-490;

(C) "New hospital" means a hospital as it exists after the approval of an agreement pursuant to section 19a-486b or a certificate of need application for a transfer of ownership of a hospital;

(D) "Purchaser" means a person who is acquiring, or has acquired, any assets of a hospital through a transfer of ownership of a hospital;

(E) "Transacting party" means a purchaser and any person who is a party to a proposed agreement for transfer of ownership of a hospital;

(F) "Transfer" means to sell, transfer, lease, exchange, option, convey, give or otherwise dispose of or transfer control over, including, but not limited to, transfer by way of merger or joint venture not in the ordinary course of business; and

(G) "Transfer of ownership of a hospital" means a transfer that impacts or changes the governance or controlling body of a hospital, including, but not limited to, all affiliations, mergers or any sale or transfer of net assets of a hospital and for which a certificate of need application or a certificate of need determination letter is filed on or after December 1, 2015.**]**

(b) In any deliberations involving a certificate of need application filed pursuant to subdivision (5) of subsection (a) of section 19a-638, as amended by this act, the office shall take into consideration and make written findings concerning each of the following guidelines and principles, as applicable:

(1) Whether the proposal is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;

(2) Whether the proposal is aligned with the state-wide health care facilities and services plan established under section 19a-634, as amended by this act, including whether the proposal will affect individuals in geographic areas that are underserved or have reduced access to specific types of health care services;

(3) Whether the applicant has satisfactorily demonstrated that the proposal will not adversely impact quality, accessibility and cost effectiveness of health care delivery in the region;

(4) The applicant's past provision of health care services to relevant patient populations and payer mix, including whether the applicant has satisfactorily demonstrated how the proposal will not adversely impact access to services by Medicaid recipients and indigent persons;

(5) Whether the applicant has satisfactorily identified the population that currently utilizes a service proposed for termination, reduction or relocation and satisfactorily demonstrated that the identified population has access to alternative locations in which such population may be able to obtain the services proposed for termination, reduction or relocation;

(6) The utilization of existing health care facilities and health care services in the service area of the applicant;

(7) Whether the applicant has demonstrated good cause for a proposed termination, reduction or relocation that (A) will result in reduced access to services by Medicaid recipients or indigent persons, or (B) is located in a geographic area that is underserved or has reduced access to specific types of services, provided good cause shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers; and

(8) Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the patient choice of provider in the geographic region.

[(2)**]** (c) In any deliberations involving a certificate of need application filed pursuant to subdivision (3) of subsection (a) of section 19a-638, **[**that involves the transfer of ownership of a hospital, the office shall, in addition to the guidelines and principles set forth in subsection (a) of this section and those prescribed through regulation

pursuant to subsection (c) of this section,**]** as amended by this act, the office shall take into consideration and make written findings concerning each of the following guidelines and principles, as applicable:

[(A)**]** (1) Whether the applicant fairly considered alternative proposals or offers in light of the purpose of maintaining health care provider diversity and consumer choice in the health care market and access to affordable quality health care for the affected community; **[**and**]**

[(B)**]** (2) Whether the plan submitted pursuant to section 19a-639a, as amended by this act, demonstrates, in a manner consistent with this chapter, how health care services will be provided by the new hospital for the first three years following the transfer of ownership of the hospital, including any consolidation, reduction, elimination or expansion of existing services or introduction of new services; **[**.**]**

(3) Whether the proposed project is aligned with the state-wide health care facilities and services plan established under section 19a-634, as amended by this act, including whether the proposed project will serve individuals in geographic areas that are underserved or have reduced access to specific types of health care services;

(4) Whether the applicant has satisfactorily demonstrated that the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region and that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care;

(5) The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including whether the applicant has satisfactorily demonstrated how the proposal will provide access to services by Medicaid recipients and indigent persons; and

(6) Whether the applicant has satisfactorily demonstrated that the

proposal will not negatively impact patient choice of provider in the geographic region.

[(3)**]** (d) The office shall deny any certificate of need application involving a transfer of ownership of a hospital unless the commissioner finds that the affected community will be assured of continued access to high quality and affordable health care after accounting for any proposed change impacting hospital staffing.

[(4)**]** (e) The office may deny any certificate of need application involving a transfer of ownership of a hospital subject to a cost and market impact review pursuant to section 19a-639f, as amended by this act, if the commissioner finds that **[**(A)**]** (1) the affected community will not be assured of continued access to high quality and affordable health care after accounting for any consolidation in the hospital and health care market that may lessen health care provider diversity, consumer choice and access to care, and **[**(B)**]** (2) any likely increases in the prices for health care services or total health care spending in the state may negatively impact the affordability of care.

[(5) The office may place any conditions on the approval of a certificate of need application involving a transfer of ownership of a hospital consistent with the provisions of this chapter. Before placing any such conditions, the office shall weigh the value of such conditions in promoting the purposes of this chapter against the individual and cumulative burden of such conditions on the transacting parties and the new hospital. For each condition imposed, the office shall include a concise statement of the legal and factual basis for such condition and the provision or provisions of this chapter that it is intended to promote. Each condition shall be reasonably tailored in time and scope. The transacting parties or the new hospital shall have the right to make a request to the office for an amendment to, or relief from, any condition based on changed circumstances, hardship or for other good cause.**]**

(f) In deliberations, as described in subsection (a) of this section, there shall be a presumption in favor of approving the certificate of

need application for a transfer of ownership of a large group practice, as described in subdivision (4) of subsection (a) of section 19a-638, as amended by this act, when an offer was made in response to a request for proposal or similar voluntary offer for sale.

[(e)**]** (g) (1) If the certificate of need application (A) involves the transfer of ownership of a hospital, (B) the purchaser is a hospital, as defined in section 19a-490, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars or a hospital system, as defined in section 19a-486i, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars, or any person that is organized or operated for profit, and (C) such application is approved, the office shall hire an independent consultant, who shall have no previous financial interest with the hospital or hospital system, or any affiliate of the hospital or hospital system, no previous sanctions and no adverse decisions regarding monitoring activities, to serve as a post-transfer compliance reporter for a period of three years after completion of the transfer of ownership of the hospital. Such reporter shall, at a minimum: (i) Meet with representatives of the purchaser, the new hospital and members of the affected community served by the new hospital not less than quarterly; and (ii) report to the office not less than quarterly concerning (I) efforts the purchaser and representatives of the new hospital have taken to comply with any conditions the office placed on the approval of the certificate of need application and plans for future compliance, and (II) community benefits and uncompensated care provided by the new hospital. The purchaser shall give the reporter access to its records and facilities for the purposes of carrying out the reporter's duties. The purchaser shall hold a public hearing in the municipality in which the new hospital is located not less than annually during the reporting period to provide for public review and comment on the reporter's reports and findings.

(2) If the reporter finds that the purchaser has breached a condition of the approval of the certificate of need application, the office may **[**,

in**]** take one or more of the following actions: (A) In consultation with the purchaser, the reporter and any other interested parties it deems appropriate, implement a performance improvement plan designed to remedy the conditions identified by the reporter and continue the reporting period for up to one year following a determination by the office that such conditions have been resolved; (B) institute an action to enjoin the purchaser from engaging in conduct in violation of the certificate of need; or (C) impose a civil penalty in accordance with section 19a-653, as amended by this act. For the breach of conditions specifying cost or price limits, the office may require partial or full refunding or repayment of the amount in excess of the conditioned limits to the affected payer, as applicable.

(3) **[**The purchaser shall provide funds, in an amount determined by the office not to exceed two hundred thousand dollars annually, for the hiring of the post-transfer compliance reporter.**]** Upon the filing of an application involving the transfer of ownership, the purchaser shall establish an escrow account pursuant to a formal escrow agreement provided by the office for the purpose of paying the bills for services provided by the independent consultant. The purchaser shall initially fund the escrow account with two hundred thousand dollars. The escrow agent shall pay such bills out of the escrow account directly to the independent consultant not later than thirty days after receipt of each bill by the purchaser.

[(f) Nothing in subsection (d) or (e) of this section shall apply to a transfer of ownership of a hospital in which either a certificate of need application is filed on or before December 1, 2015, or where a certificate of need determination letter is filed on or before December 1, 2015.**]**

(h) The office may place any conditions on the approval of any certificate of need application consistent with the provisions of this chapter. Before placing any such conditions, the office shall weigh the value of such conditions in promoting the purposes of this chapter against the individual and cumulative burden of such conditions on

the applicant or any transacting parties. For each condition imposed, the office shall include a concise statement of the legal and factual basis for such condition and the provision or provisions of this chapter that it is intended to promote. Any condition imposed by the office shall be reasonably tailored in time and scope. The applicant or any applicable transacting parties shall have the right to make a request to the office for an amendment to, or relief from, any condition based on changed circumstances, hardship or for other good cause.

(i) The Commissioner of Public Health may adopt regulations, in accordance with the provisions of chapter 54 to carry out the provisions of this section.

Sec. 7. Section 19a-639a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) An application for a certificate of need shall be filed with the office in accordance with the provisions of this section and any regulations adopted by the Department of Public Health. The application shall address the guidelines and principles set forth in (1) subsection (a) of section 19a-639, as amended by this act, and (2) regulations adopted by the department. The applicant shall include with the application a nonrefundable application fee of five hundred dollars.

(b) **[**Prior**]** Not later than twenty days prior to the filing of a certificate of need application, the applicant shall (1) publish notice for not less than three consecutive days that an application is to be submitted to the office in a newspaper having a substantial circulation in the area where the project is to be located, and (2) request the publication of notice in at least two sites within the affected community that are commonly accessed by the public, such as a town hall or library, and on any existing Internet web site of the municipality or local health department. Such notice shall **[**(1) be published (A) not later than twenty days prior to the date of filing of the certificate of need application, and (B) for not less than three consecutive days, and (2)**]** contain a brief description of the nature of

the project and the street address where the project is to be located. An applicant shall file the certificate of need application with the office not later than ninety days after publishing notice of the application in accordance with the provisions of this subsection. The office shall not accept the applicant's certificate of need application for filing unless the application is accompanied by the application fee prescribed in subsection (a) of this section and proof of compliance with the publication requirements prescribed in this subsection.

(c) (1) Not later than five business days after receipt of a properly filed certificate of need application, the office shall publish notice of the application on its Internet web site. Not later than thirty days after the date of filing of the application, the office may request such additional information as the office determines necessary to complete the application. In addition to any information requested by the office, if the application involves the transfer of ownership of a hospital, as defined in section **[**19a-639**]** 19a-630, as amended by this act, the applicant shall submit to the office (A) a plan demonstrating how health care services will be provided by the new hospital for the first three years following the transfer of ownership of the hospital, including any consolidation, reduction, elimination or expansion of existing services or introduction of new services, and (B) the names of persons currently holding a position with the hospital to be purchased or the purchaser, as defined in section **[**19a-639**]** 19a-630, as amended by this act, as an officer, director, board member or senior manager, whether or not such person is expected to hold a position with the hospital after completion of the transfer of ownership **[**of the hospital**]** and any salary, severance, stock offering or any financial gain, current or deferred, such person is expected to receive as a result of, or in relation to, the transfer of ownership of the hospital.

(2) The applicant shall, not later than sixty days after the date of the office's request, submit any requested information and any information required under this subsection to the office. If an applicant fails to submit such information to the office within the sixty-day period, the office shall consider the application to have been

withdrawn.

(d) Upon determining that an application is complete, the office shall provide notice of this determination to the applicant and to the public in accordance with regulations adopted by the department. In addition, the office shall post such notice on its Internet web site and provide the link to the completed application to any entity that published notice in accordance with subsection (b) of this section for publication of such completed application. The date on which the office posts such notice on its Internet web site shall begin the review period. Except as provided in this subsection, (1) the review period for a completed application shall be ninety days from the date on which the office posts such notice on its Internet web site; and (2) the office shall issue a decision on a completed application prior to the expiration of the ninety-day review period. The review period for a completed application that involves a transfer of a large group practice, as described in subdivision **[**(3)**]** (4) of subsection (a) of section 19a-638, as amended by this act, when the offer was made in response to a request for proposal or similar voluntary offer for sale, shall be sixty days from the date on which the office posts notice on its Internet web site. Upon request or for good cause shown, the office may extend the review period for a period of time not to exceed sixty days. If the review period is extended, the office shall issue a decision on the completed application prior to the expiration of the extended review period. If the office holds a public hearing concerning a completed application in accordance with subsection (e) or (f) of this section, the office shall issue a decision on the completed application not later than sixty days after the date the office closes the public hearing record.

(e) **[**Except as provided in this subsection, the**]** The office shall hold a public hearing on a properly filed and completed certificate of need application if three or more individuals or an individual representing an entity with five or more people submits a request, in writing, that a public hearing be held on the application. For a properly filed and completed certificate of need application involving a transfer of ownership of a large group practice, as described in subdivision **[**(3)**]**

(4) of subsection (a) of section 19a-638, as amended by this act, when an offer was made in response to a request for proposal or similar voluntary offer for sale, a public hearing shall be held if twenty-five or more individuals or an individual representing twenty-five or more people submits a request, in writing, that a public hearing be held on the application. Any request for a public hearing shall be made to the office not later than thirty days after the date the office determines the application to be complete.

(f) (1) The office shall hold a public hearing [with respect to each] on a properly filed and completed certificate of need application [filed pursuant to section 19a-638 after December 1, 2015,] that concerns any transfer of ownership [involving] of a hospital. Such hearing shall be held in the municipality in which the hospital that is the subject of the application is located.

(2) The office may hold a public hearing with respect to any certificate of need application submitted under this chapter. The office shall provide not less than [two] three weeks' advance notice to the applicant, in writing, and the applicant shall provide not less than two weeks' advance notice to the public by (A) publication in a newspaper having a substantial circulation in the area served by the health care facility or provider, and (B) requesting publication in at least two sites within the affected community that are commonly accessed by the public, such as a town hall or library and on any existing Internet web site of the municipality or local health department. In conducting its activities under this chapter, the office may hold a public hearing on applications of a similar nature at the same time.

(g) If the certificate of need application involves the transfer of ownership of a hospital, the applicant shall include in a single application all information related to all supplemental transactions associated with such transfer of ownership that would otherwise require a separate certificate of need application. Any such application shall be subject to a cost and market impact review pursuant to section 19a-639f, as amended by this act.

(h) The office may retain an independent consultant with expertise in the specific area of health care that is the subject of a pending application filed by an applicant if the review and analysis of an application cannot reasonably be conducted by the office without the expertise of an industry analyst or other actuarial consultant. Upon a determination by the office that an independent consultant is required, the applicant shall establish an escrow account pursuant to a formal escrow agreement provided by the office for the purpose of paying the bills for services provided by the independent consultant. The applicant shall initially fund the escrow account in an amount to be determined by the office, not to exceed twenty thousand dollars. The office shall submit bills for independent consultant services to the applicant. The escrow agent shall pay such bills out of the escrow account directly to the independent consultant not later than thirty days after receipt of each bill by the applicant. Such bills shall not exceed twenty thousand dollars per application. The provisions of chapter 57, sections 4-212 to 4-219, inclusive, and section 4e-19 shall not apply to any agreement executed pursuant to this subsection.

[(g)**]** (i) The Commissioner of Public Health may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner holds a public hearing prior to implementing the policies and procedures and prints notice of intent to adopt regulations on the department's Internet web site and the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Sec. 8. Subsection (e) of section 19a-639b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(e) The Commissioner of Public Health may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation,

provided the commissioner holds a public hearing prior to implementing the policies and procedures and prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted. **[**Final regulations shall be adopted by December 31, 2011.**]**

Sec. 9. Section 19a-639c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) Any health care facility that proposes to relocate a facility shall submit a **[**letter**]** determination request to the office **[**, as described in subsection (c) of section 19a-638. In addition to the requirements prescribed in said subsection (c), in such letter the health care facility shall demonstrate**]** that describes the project and demonstrates to the satisfaction of the office that the population served by the health care facility and the payer mix will not substantially change as a result of the facility's proposed relocation. If the facility is unable to demonstrate to the satisfaction of the office that the population served and the payer mix will not substantially change as a result of the proposed relocation, the health care facility shall apply for certificate of need approval pursuant to subdivision (1) of subsection (a) of section 19a-638, as amended by this act, in order to effectuate the proposed relocation.

(b) The Commissioner of Public Health may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner holds a public hearing prior to implementing the policies and procedures and prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted. **[**Final regulations shall be adopted by December 31, 2011.**]**

Sec. 10. Section 19a-639e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) **[**Unless otherwise required to file a certificate of need application pursuant to the provisions of subsection (a) of section 19a-638, any health care facility that proposes to terminate a service that was authorized pursuant to a certificate of need issued under this chapter shall file a modification request with**]** Any hospital or hospital system proposing to terminate or reduce inpatient or outpatient services due to insufficient patient volume or the lack of practitioners to support the effective delivery of care, as specified in subdivision (5) of subsection (a) of section 19a-638, as amended by this act, shall submit a determination request to the office not later than sixty days prior to the proposed date of **[**the**]** such termination or reduction of the service. Such request shall include (1) the date on which the service or services will be terminated or reduced by the hospital or hospital system, (2) documentation that demonstrates that the hospital or hospital system is experiencing insufficient patient volume or lack of practitioners for the service, resulting in such hospital or hospital system being unable to support effective delivery of care, and (3) whether the termination or reduction of service will occur in a geographic area that has been identified in the state-wide health care facilities and services plan as being underserved or having reduced access to specific types of health care services. Any hospital or hospital system that is unable to demonstrate to the satisfaction of the office that the proposed termination or reduction is due to insufficient patient volume or the lack of practitioners to support the effective delivery of care shall be required to file a certificate of need pursuant to subsection (a) of section 19a-638, as amended by this act. The office may request additional information from **[**the health care facility**]** such hospital or hospital system as necessary to process the **[**modification**]** request. **[**In addition, the office shall hold a public hearing on any request from a health care facility to terminate a service pursuant to this section if three or more individuals or an individual representing an entity with five or more people submits a request, in writing, that a public hearing be held on the health care facility's proposal to terminate a service.

(b) Unless otherwise required to file a certificate of need application pursuant to the provisions of subsection (a) of section 19a-638, any health care facility that proposes to terminate all services offered by such facility, that were authorized pursuant to one or more certificates of need issued under this chapter, shall provide notification to the office not later than sixty days prior to the termination of services and such facility shall surrender its certificate of need not later than thirty days prior to the termination of services.**]**

(b) Any person, physician, provider or hospital proposing to acquire a scanner that utilizes imaging techniques, including, but not limited to, computed tomography, magnetic resonance imaging, positron emission tomography, positron emission tomography-computed tomography or single-photon emission computed tomography shall submit a determination request to the office not later than sixty days prior to the proposed date of the acquisition of the equipment, unless such proposed acquisition is for the purpose of replacing an existing scanner with a similar scanner, if such existing scanner was acquired through a certificate of need approval or a certificate of need determination, provided a person, physician, provider or hospital notifies the office of the date on which the scanner is replaced and the disposition of the replaced scanner. Such request shall include (1) the date on which the equipment is to be acquired, (2) the methods such person, physician, provider or hospital will utilize to minimize the practice of patient referrals in which the referring provider will stand to financially gain from such referral, (3) demonstration that Medicaid recipients and indigent persons will have access to the services provided utilizing the equipment acquired, and (4) whether the equipment will be utilized in a geographic area that has been identified in the state-wide health care facilities and services plan as being underserved or having reduced access to specific types of health care services. Any person, physician, provider or hospital that fails to sufficiently demonstrate to the satisfaction of the office that methods will be utilized to minimize the practice of patient referrals in which the referring provider will stand to financially gain from such referral and that Medicaid recipients and indigent persons will have access to

the services provided utilizing the equipment acquired shall be required to file a certificate of need pursuant to subsection (a) of section 19a-638, as amended by this act. The office may request additional information from such person, physician, provider or hospital as necessary to process the request.

(c) Any person proposing to establish a new hospital, new freestanding emergency department or new outpatient surgical facility in areas identified in the state-wide health care facilities and services plan as underserved or having reduced access to specific types of health care services shall submit a determination request to the office not later than sixty days prior to the proposed establishment of such new health care facility. Such request shall include (1) the date on which such new health care facility is proposed to be operational, (2) a demonstration that the new health care facility will be located in a geographic area that has been identified in the state-wide health care facilities and services plan as being underserved or having reduced access to specific types of health care services, and (3) a demonstration that Medicaid recipients and indigent persons will have access to the services provided. Any person submitting a determination request that fails to sufficiently demonstrate to the satisfaction of the office that such new health care facility will be located in a geographic area that has been identified in the state-wide health care facilities and services plan as being underserved or having reduced access to specific types of health care services and will serve Medicaid recipients and indigent persons shall be required to file a certificate of need pursuant to subsection (a) of section 19a-638, as amended by this act. The office may request additional information from such person as necessary to process the request.

[(c)**]** (d) Unless otherwise required to file a certificate of need application pursuant to the provisions of subsection (a) of section 19a-638, as amended by this act, any health care facility that proposes to terminate the operation of a facility or service **[**for which a certificate of need was not obtained**]** shall notify the office not later than sixty days prior to terminating the operation of the facility or service. Such

notification shall include (1) the name and location of the health care facility, (2) the reason for terminating the operation of the health care facility or service, (3) other locations where patients may be able to obtain the services that are provided by the health care facility that intends to terminate its operation or services, and (4) the date the health care facility will be terminating its operation or service definition.

[(d)**]** (e) The Commissioner of Public Health may adopt regulations, in accordance with chapter 54, to implement the provisions of this section. In addition, the commissioner may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner holds a public hearing prior to implementing the policies and procedures and prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted. **[**Final regulations shall be adopted by December 31, 2015.**]**

Sec. 11. Section 19a-639f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) For purposes of this section:

(1) "Dispersed service area" means a geographic area in which a provider organization delivers health care services (A) based on the number of zip codes, towns, counties or primary service areas in such geographic area, and (B) the standards of which may vary based upon the population density of such geographic area as compared to the various other regions of the state.

(2) "Health status adjusted total medical expense" means a measure of the total cost of care, adjusted by health status, for the patient population associated with a provider group, which may be (A) calculated based on allowed claims for all categories of medical

expenses and all non-claims-related payments to providers, and (B) expressed on a per member per month basis.

(3) "Major service category" means a set of service categories that may include (A) acute hospital inpatient services, by Medicare Severity-Diagnosis Related Groups, (B) outpatient and ambulatory services, by categories as defined by the federal Centers for Medicare and Medicaid, and (C) behavioral, substance use disorder and mental health services, by categories as defined by the federal Centers for Medicare and Medicaid.

(4) "Relative prices" means a measure that (A) compares amounts paid to a provider relative to other providers for the same health care services, and (B) may be calculated based on the contractually negotiated amounts paid to providers by each private and public health carrier for health care services, including, but not limited to, non-claims-related payments, and expressed in the aggregate relative to the payer's network-wide average amount paid to providers.

(5) "Total health care spending" means a measure of all health care expenditures in the state from public and private sources, including (A) all categories of medical expenses and all non-claims-related payments to providers, (B) all patient cost-sharing amounts, including, but not limited to, deductibles and copayments, and (C) the net cost of private health insurance, which may be expressed as an annual per capita sum.

[(a)**]** (b) The Office of Healthcare Access division within the Department of Public Health shall conduct a cost and market impact review in each case where (1) an application for a certificate of need filed pursuant to section 19a-638, as amended by this act, involves the transfer of ownership of a hospital, **[**as defined in section 19a-639,**]** and (2) the purchaser is a hospital, **[**as defined in section 19a-490,**]** whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars, or a hospital system, **[**as defined in section 19a-486i,**]** whether located within or outside the state, that had net patient

revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars or any person that is organized or operated for profit.

[(b)**]** (c) Not later than twenty-one days after receipt of a properly filed certificate of need application involving the transfer of ownership of a hospital **[**filed on or after December 1, 2015, as described in subsection (a) of this section,**]** the office shall initiate such cost and market impact review by sending the transacting parties a written notice that shall contain a description of the basis for the cost and market impact review as well as a request for information and documents. Not later than thirty days after receipt of such notice, the transacting parties shall submit to the office a written response. Such response shall include, but need not be limited to, any information or documents requested by the office concerning the transfer of ownership of the hospital. The office shall have the powers with respect to the cost and market impact review as provided in section 19a-633.

[(c)**]** (d) The office shall keep confidential all nonpublic information and documents obtained pursuant to this section and shall not disclose the information or documents to any person without the consent of the person that produced the information or documents, except in a preliminary report or final report issued in accordance with this section if the office believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. Such information and documents shall not be deemed a public record, under section 1-210, and shall be exempt from disclosure.

[(d)**]** (e) The cost and market impact review conducted pursuant to this section shall examine factors relating to the businesses and relative market positions of the transacting parties as defined in **[**subsection (d) of section 19a-639**]** section 19a-630, as amended by this act, and may include, but need not be limited to: (1) The transacting parties' size and market share within its primary service area, by major service category

and within its dispersed service areas; (2) the transacting parties' prices for services, including the transacting parties' relative prices compared to other health care providers for the same services in the same market; (3) the transacting parties' health status adjusted total medical expense, including the transacting parties' health status adjusted total medical expense compared to that of similar health care providers; (4) the quality of the services provided by the transacting parties, including patient experience; (5) the transacting parties' cost and cost trends in comparison to total health care expenditures state wide; (6) the availability and accessibility of services similar to those provided by each transacting party, or proposed to be provided as a result of the transfer of ownership **[**of a hospital**]** within each transacting party's primary service areas and dispersed service areas; (7) the impact of the proposed transfer of ownership **[**of the hospital**]** on competing options for the delivery of health care services within each transacting party's primary service area and dispersed service area including the impact on existing service providers; (8) the methods used by the transacting parties to attract patient volume and to recruit or acquire health care professionals or facilities; (9) the role of each transacting party in serving at-risk, underserved and government payer patient populations, including those with behavioral, substance use disorder and mental health conditions, within each transacting party's primary service area and dispersed service area; (10) the role of each transacting party in providing low margin or negative margin services within each transacting party's primary service area and dispersed service area; (11) consumer concerns, including, but not limited to, complaints or other allegations that a transacting party has engaged in any unfair method of competition or any unfair or deceptive act or practice; and (12) any other factors that the office determines to be in the public interest.

[(e)**]** (f) Not later than ninety days after the office determines that there is substantial compliance with any request for documents or information issued by the office in accordance with this section, or a later date set by mutual agreement of the office and the transacting parties, the office shall make factual findings and issue a preliminary

report on the cost and market impact review. Such preliminary report shall include, but shall not be limited to, an indication as to whether a transacting party meets the following criteria: (1) Currently has or, following the proposed transfer of operations of the hospital, is likely to have a dominant market share for the services the transacting party provides; and (2) (A) currently charges or, following the proposed transfer of operations of the hospital, is likely to charge prices for services that are materially higher than the median prices charged by all other health care providers for the same services in the same market, or (B) currently has or, following the proposed transfer of operations of a hospital, is likely to have a health status adjusted total medical expense that is materially higher than the median total medical expense for all other health care providers for the same service in the same market.

[(f)**]** (g) The transacting parties that are the subject of the cost and market impact review may respond in writing to the findings in the preliminary report issued in accordance with subsection **[**(e)**]** (f) of this section not later than thirty days after the issuance of the preliminary report. Not later than sixty days after the issuance of the preliminary report, the office shall issue a final report of the cost and market impact review. The office shall refer to the Attorney General any final report on any proposed transfer of ownership that meets the criteria described in subsection **[**(e)**]** (f) of this section.

[(g)**]** (h) Nothing in this section shall prohibit a transfer of ownership of a hospital, provided any such proposed transfer shall not be completed (1) less than thirty days after the office has issued a final report on a cost and market impact review, if such review is required, or (2) while any action brought by the Attorney General pursuant to subsection **[**(h)**]** (i) of this section is pending and before a final judgment on such action is issued by a court of competent jurisdiction.

[(h)**]** (i) After the office refers a final report on a transfer of ownership of a hospital to the Attorney General under subsection **[**(f)**]** (g) of this section, the Attorney General may: (1) Conduct an

investigation to determine whether the transacting parties engaged, or, as a result of completing the transfer of ownership of the hospital, are expected to engage in unfair methods of competition, anti-competitive behavior or other conduct in violation of chapter 624 or 735a or any other state or federal law; and (2) if appropriate, take action under chapter 624 or 735a or any other state law to protect consumers in the health care market. The office's final report may be evidence in any such action.

[(i)**]** (j) For the purposes of this section, the provisions of chapter 735a may be directly enforced by the Attorney General. Nothing in this section shall be construed to modify, impair or supersede the operation of any state antitrust law or otherwise limit the authority of the Attorney General to (1) take any action against a transacting party as authorized by any law, or (2) protect consumers in the health care market under any law. Notwithstanding subdivision (1) of subsection (a) of section 42-110c, the transacting parties shall be subject to chapter 735a.

[(j)**]** (k) The office shall retain an independent consultant with expertise on the economic analysis of the health care market and health care costs and prices to conduct each cost and market impact review, as described in this section. **[**The office shall submit bills for such services to the purchaser, as defined in subsection (d) of section 19a-639. Such purchaser**]** Upon the filing of an application involving the transfer of ownership of a hospital, the purchaser shall establish an escrow account pursuant to a formal escrow agreement provided by the Office of Health Care Access for the purpose of paying the bills for services provided by the independent consultant. The purchaser shall initially fund the escrow account with two hundred thousand dollars. The office shall submit bills for independent consultant services to the purchaser, as defined in section 19a-630, as amended by this act. The escrow agent shall pay such bills out of the escrow account directly to the independent consultant not later than thirty days after receipt of each bill by the purchaser. Such bills shall not exceed two hundred thousand dollars per application. The provisions of chapter 57, sections

4-212 to 4-219, inclusive, and section 4e-19 shall not apply to any agreement executed pursuant to this subsection.

[(k)**]** (l) Any employee of the office who directly oversees or assists in conducting a cost and market impact review shall not take part in factual deliberations or the issuance of a preliminary or final decision on the certificate of need application concerning the transfer of ownership **[**of a hospital**]** that is the subject of such cost and market impact review.

[(l)**]** (m) The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54, concerning cost and market impact reviews and to administer the provisions of this section. **[**Such regulations shall include definitions of the following terms: "Dispersed service area", "health status adjusted total medical expense", "major service category", "relative prices", "total health care spending" and "health care services".**]** The commissioner may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the commissioner publishes notice of intention to adopt the regulations on the Department of Public Health's Internet web site and the eRegulations System not later than twenty days after implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are effective.

Sec. 12. Section 19a-653 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) **[**Any**]** The Department of Public Health may impose a civil penalty of up to one thousand dollars per day on any person or health care facility or institution that **[**is required to**]** negligently fails to (1) file a certificate of need for any of the activities described in section 19a-638, **[**and any person or health care facility or institution that is required to**]** as amended by this act, for each day such activities are conducted without the certificate of need approval, (2) file data or information under any public or special act or under this chapter or

sections 19a-486 to 19a-486h, inclusive, or any regulation adopted or order issued under this chapter or said sections **[**, which wilfully fails to seek certificate of need approval for any of the activities described in section 19a-638 or to so file within prescribed time periods, shall be subject to a civil penalty of up to one thousand dollars a day for each day such person or health care facility or institution conducts any of the described activities without certificate of need approval as required by section 19a-638 or for each day such information is missing, incomplete or inaccurate**]** within prescribed time periods, for each day such data or information is missing, incomplete or inaccurate, or (3) comply with a condition in accordance with subsection (h) of section 19a-639, as amended by this act, for each day such condition is breached. Any civil penalty authorized by this section shall be imposed by the Department of Public Health in accordance with subsections (b) to (e), inclusive, of this section.

(b) If the Department of Public Health has reason to believe that a violation has occurred for which a civil penalty is authorized by subsection (a) of this section or subsection (e) of section 19a-632, it shall notify the person or health care facility or institution by first-class mail or personal service. The notice shall include: (1) A reference to the sections of the statute or regulation involved; (2) a short and plain statement of the matters asserted or charged; (3) a statement of the amount of the civil penalty or penalties to be imposed; (4) the initial date of the imposition of the penalty; and (5) a statement of the party's right to a hearing.

(c) The person or health care facility or institution to whom the notice is addressed shall have fifteen business days from the date of mailing of the notice to make written application to the office to request (1) a hearing to contest the imposition of the penalty, or (2) an extension of time to file the required data. A failure to make a timely request for a hearing or an extension of time to file the required data or a denial of a request for an extension of time shall result in a final order for the imposition of the penalty. All hearings under this section shall be conducted pursuant to sections 4-176e to 4-184, inclusive. The

Department of Public Health may grant an extension of time for filing the required data or mitigate or waive the penalty upon such terms and conditions as, in its discretion, it deems proper or necessary upon consideration of any extenuating factors or circumstances.

(d) A final order of the Department of Public Health assessing a civil penalty shall be subject to appeal as set forth in section 4-183 after a hearing before the office pursuant to subsection (c) of this section, except that any such appeal shall be taken to the superior court for the judicial district of New Britain. Such final order shall not be subject to appeal under any other provision of the general statutes. No challenge to any such final order shall be allowed as to any issue which could have been raised by an appeal of an earlier order, denial or other final decision by the Department of Public Health.

(e) If any person or health care facility or institution fails to pay any civil penalty under this section, after the assessment of such penalty has become final the amount of such penalty may be deducted from payments to such person or health care facility or institution from the Medicaid account.

Sec. 13. Subsection (a) of section 19a-486d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) The commissioner shall deny an application filed pursuant to subsection (d) of section 19a-486a unless the commissioner finds that: (1) In a situation where the asset or operation to be transferred provides or has provided health care services to the uninsured or underinsured, the purchaser has made a commitment to provide health care to the uninsured and the underinsured; (2) in a situation where health care providers or insurers will be offered the opportunity to invest or own an interest in the purchaser or an entity related to the purchaser safeguard procedures are in place to avoid a conflict of interest in patient referral; and (3) certificate of need authorization is justified in accordance with chapter 368z. The commissioner may contract with any person, including, but not limited to, financial or

actuarial experts or consultants, or legal experts with the approval of the Attorney General, to assist in reviewing the completed application. The commissioner shall submit any bills for such contracts to the purchaser. Such bills shall not exceed one hundred fifty thousand dollars. [The purchaser] Upon the filing of an application pursuant to subsection (d) of section 19a-486a, the purchaser shall establish an escrow account pursuant to a formal escrow agreement provided by the Office of Health Care Access for the purpose of paying bills for services provided by the consultant. The purchaser shall initially fund the escrow account with one hundred fifty thousand dollars. The escrow agent shall pay such bills [no] out of the escrow account directly to the expert or consultant not later than thirty days after the date of receipt of [such bills] each bill by the purchaser.

Sec. 14. Section 19a-486i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) As used in this section:

(1) "Affiliation" means the formation of a relationship between two or more entities that permits the entities to negotiate jointly with third parties over rates for professional medical services;

(2) "Captive professional entity" means a partnership, professional corporation, limited liability company or other entity formed to render professional services in which a partner, a member, a shareholder or a beneficial owner is a physician, directly or indirectly, employed by, controlled by, subject to the direction of, or otherwise designated by (A) a hospital, (B) a hospital system, (C) a medical school, (D) a medical foundation, organized pursuant to subsection (a) of section 33-182bb, or (E) any entity that controls, is controlled by or is under common control with, whether through ownership, governance, contract or otherwise, another person, entity or organization described in subparagraphs (A) to (D), inclusive, of this subdivision;

(3) "Hospital" has the same meaning as provided in section [19a-490] 19a-646;

(4) "Hospital system" means: (A) A parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance or membership; **[**,**]** or (B) a hospital and any entity affiliated with such hospital through ownership, governance or membership;

(5) "Health care provider" has the same meaning as provided in section 19a-17b;

(6) "Medical foundation" means a medical foundation formed under chapter 594b;

(7) "Physician" has the same meaning as provided in section 20-13a;

(8) "Person" has the same meaning as provided in section 35-25;

(9) "Professional corporation" has the same meaning as provided in section 33-182a;

(10) "Group practice" means two or more physicians, legally organized in a partnership, professional corporation, limited liability company formed to render professional services, medical foundation, not-for-profit corporation, faculty practice plan or other similar entity (A) in which each physician who is a member of the group provides substantially the full range of services that the physician routinely provides, including, but not limited to, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel; (B) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group practice and amounts so received are treated as receipts of the group; or (C) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group. An entity that otherwise meets the definition of group practice under this section shall be considered a group practice although its shareholders, partners or owners of the group practice include single-physician professional corporations, limited liability

companies formed to render professional services or other entities in which beneficial owners are individual physicians; and

(11) "Primary service area" means the smallest number of zip codes from which the group practice draws at least seventy-five per cent of its patients.

(b) At the same time that any person conducting business in this state that files merger, acquisition or any other information regarding market concentration with the Federal Trade Commission or the United States Department of Justice, in compliance with the Hart-Scott-Rodino Antitrust Improvements Act, 15 USC 18a, where a hospital, hospital system or other health care provider is a party to the merger or acquisition that is the subject of such information, such person shall provide written notification to the Attorney General of such filing and, upon the request of the Attorney General, provide a copy of such merger, acquisition or other information.

(c) Not less than thirty days prior to the effective date of any transaction that results in a material change to the business or corporate structure of a group practice, the parties to the transaction shall submit written notice to the Attorney General of such material change. For purposes of this subsection, a material change to the business or corporate structure of a group practice includes: (1) The merger, consolidation or other affiliation of a group practice with (A) another group practice that results in a group practice comprised of eight or more physicians, or (B) a hospital, hospital system, captive professional entity, medical foundation or other entity organized or controlled by such hospital or hospital system; (2) the acquisition of all or substantially all of (A) the properties and assets of a group practice, or (B) the capital stock, membership interests or other equity interests of a group practice by (i) another group practice that results in a group practice comprised of eight or more physicians, or (ii) a hospital, hospital system, captive professional entity, medical foundation or other entity organized or controlled by such hospital or hospital system; (3) the employment of all or substantially all of the physicians

of a group practice by (A) another group practice that results in a group practice comprised of eight or more physicians, or (B) a hospital, hospital system, captive professional entity, medical foundation or other entity organized by, controlled by or otherwise affiliated with such hospital or hospital system; and (4) the acquisition of one or more insolvent group practices by (A) another group practice that results in a group practice comprised of eight or more physicians, or (B) a hospital, hospital system, captive professional entity, medical foundation or other entity organized by, controlled by or otherwise affiliated with such hospital or hospital system.

(d) (1) The written notice required under subsection (c) of this section shall identify each party to the transaction and describe the material change as of the date of such notice to the business or corporate structure of the group practice, including: (A) A description of the nature of the proposed relationship among the parties to the proposed transaction; (B) the names and specialties of each physician that is a member of the group practice that is the subject of the proposed transaction and who will practice medicine with the resulting group practice, hospital, hospital system, captive professional entity, medical foundation or other entity organized by, controlled by, or otherwise affiliated with such hospital or hospital system following the effective date of the transaction; (C) the names of the business entities that are to provide services following the effective date of the transaction; (D) the address for each location where such services are to be provided; (E) a description of the services to be provided at each such location; and (F) the primary service area to be served by each such location.

(2) Not later than thirty days after the effective date of any transaction described in subsection (c) of this section, the parties to the transaction shall submit written notice to the Commissioner of Public Health. Such written notice shall include, but need not be limited to, the same information described in subdivision (1) of this subsection. The commissioner shall post a link to such notice on the Department of Public Health's Internet web site.

(e) Not less than thirty days prior to the effective date of any transaction that results in an affiliation between one hospital or hospital system and another hospital or hospital system, the parties to the affiliation shall submit written notice to the Attorney General of such affiliation. Such written notice shall identify each party to the affiliation and describe the affiliation as of the date of such notice, including: (1) A description of the nature of the proposed relationship among the parties to the affiliation; (2) the names of the business entities that are to provide services following the effective date of the affiliation; (3) the address for each location where such services are to be provided; (4) a description of the services to be provided at each such location; and (5) the primary service area to be served by each such location.

(f) Written information submitted to the Attorney General pursuant to subsections (b) to (e), inclusive, of this section shall be maintained and used by the Attorney General in the same manner as provided in section 35-42.

(g) Not later than **[**December 31, 2014**]** January 15, 2018, and annually thereafter, each hospital and hospital system shall file with the Attorney General and the Commissioner of Public Health a written report describing the activities of the group practices owned or affiliated with such hospital or hospital system. Such report shall include, for each such group practice: (1) A description of the nature of the relationship between the hospital or hospital system and the group practice; (2) the names and specialties of each physician practicing medicine with the group practice; (3) the names of the business entities that provide services as part of the group practice and the address for each location where such services are provided; (4) a description of the services provided at each such location; and (5) the primary service area served by each such location.

(h) Not later than **[**December 31, 2014**]** January 15, 2018, and annually thereafter, each group practice comprised of thirty or more physicians that is not the subject of a report filed under subsection (g)

of this section shall file with the Attorney General and the Commissioner of Public Health a written report concerning the group practice. Such report shall include, for each such group practice: (1) The names and specialties of each physician practicing medicine with the group practice; (2) the names of the business entities that provide services as part of the group practice and the address for each location where such services are provided; (3) a description of the services provided at each such location; and (4) the primary service area served by each such location.

(i) Not later than **[**December 31, 2015**]** January 15, 2018, and annually thereafter, each hospital and hospital system shall file with the Attorney General and the Commissioner of Public Health a written report describing each affiliation with another hospital or hospital system. Such report shall include: (1) The name and address of each party to the affiliation; (2) a description of the nature of the relationship among the parties to the affiliation; (3) the names of the business entities that provide services as part of the affiliation and the address for each location where such services are provided; (4) a description of the services provided at each such location; and (5) the primary service area served by each such location.

Sec. 15. Subsections (a) to (c), inclusive, of section 17b-352 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) For the purposes of this section and section 17b-353, as amended by this act, "facility" means a residential facility for persons with intellectual disability licensed pursuant to section 17a-277 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disabilities, a nursing home, rest home or residential care home, as defined in section 19a-490. "Facility" does not include a nursing home that does not participate in the Medicaid program and is associated with a continuing care facility as described in section 17b-520.

(b) Any facility which intends to (1) transfer all or part of its

ownership or control prior to being initially licensed; (2) introduce any additional function or service into its program of care or expand an existing function or service; **[**or**]** (3) terminate a service or decrease substantially its total bed capacity; or (4) relocate all or a portion of such facility's licensed beds, to a new facility or replacement facility, shall submit a complete request for permission to implement such transfer, addition, expansion, increase, termination, **[**or**]** decrease or relocation of facility beds with such information as the department requires to the Department of Social Services, provided no permission or request for permission to close a facility is required when a facility in receivership is closed by order of the Superior Court pursuant to section 19a-545. The Office of the Long-Term Care Ombudsman pursuant to section 17a-405 shall be notified by the facility of any proposed actions pursuant to this subsection at the same time the request for permission is submitted to the department and when a facility in receivership is closed by order of the Superior Court pursuant to section 19a-545.

(c) An applicant, prior to submitting a certificate of need application, shall request, in writing, application forms and instructions from the department. The request shall include: (1) The name of the applicant or applicants; (2) a statement indicating whether the application is for (A) a new, additional, expanded or replacement facility, service or function or relocation of facility beds, (B) a termination or reduction in a presently authorized service or bed capacity, or (C) any new, additional or terminated beds and their type; (3) the estimated capital cost; (4) the town where the project is or will be located; and (5) a brief description of the proposed project. Such request shall be deemed a letter of intent. No certificate of need application shall be considered submitted to the department unless a current letter of intent, specific to the proposal and in accordance with the provisions of this subsection, has been on file with the department for not less than ten business days. For purposes of this subsection, "a current letter of intent" means a letter of intent on file with the department for not more than one hundred eighty days. A certificate of need application shall be deemed withdrawn by the department, if a

department completeness letter is not responded to within one hundred eighty days. The Office of the Long-Term Care Ombudsman shall be notified by the facility at the same time as the letter of intent is submitted to the department.

Sec. 16. Section 17b-353 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) Any facility, as defined in subsection (a) of section 17b-352, as amended by this act, which proposes **[**(1) a capital expenditure**]** to incur (1) capital expenditures exceeding one million dollars, which increases facility square footage by more than five thousand square feet or five per cent of the existing square footage, whichever is greater, **[**(2) a capital expenditure**]** or (2) capital expenditures exceeding two million dollars, **[**or (3) the acquisition of major medical equipment requiring a capital expenditure in excess of four hundred thousand dollars, including the leasing of equipment or space,**]** shall submit a request for approval of such expenditure, with such information as the department requires, to the Department of Social Services. **[**Any such facility which proposes to acquire imaging equipment requiring a capital expenditure in excess of four hundred thousand dollars, including the leasing of such equipment, shall obtain the approval of the Office of Health Care Access division of the Department of Public Health in accordance with the provisions of chapter 368z, subsequent to obtaining the approval of the Commissioner of Social Services. Prior to the facility's obtaining the imaging equipment, the Commissioner of Public Health, after consultation with the Commissioner of Social Services, may elect to perform a joint or simultaneous review with the Department of Social Services.**]**

(b) An applicant, prior to submitting a certificate of need application, shall request, in writing, application forms and instructions from the department. The request shall include: (1) The name of the applicant or applicants; (2) a statement indicating whether the application is for (A) a new, additional, expanded or replacement

facility, service or function, (B) a termination or reduction in a presently authorized service or bed capacity or relocation of facility beds, or (C) any new, additional or terminated beds and their type; (3) the estimated capital cost; (4) the town where the project is or will be located; and (5) a brief description of the proposed project. Such request shall be deemed a letter of intent. No certificate of need application shall be considered submitted to the department unless a current letter of intent, specific to the proposal and in accordance with the provisions of this subsection, has been on file with the department for not less than ten business days. For purposes of this subsection, "a current letter of intent" means a letter of intent on file with the department for not more than one hundred eighty days. A certificate of need application shall be deemed withdrawn by the department if a department completeness letter is not responded to within one hundred eighty days.

(c) In conducting its activities pursuant to this section, section 17b-352, as amended by this act, or both, except as provided for in subsection (d) of this section, the Commissioner of Social Services or said commissioner's designee may hold a public hearing on an application or on more than one application, if such applications are of a similar nature with respect to the request. At least two weeks' notice of the hearing shall be given to the facility by certified mail and to the public by publication in a newspaper having a substantial circulation in the area served by the facility. Such hearing shall be held at the discretion of the commissioner in Hartford or in the area so served. The commissioner or the commissioner's designee shall consider such request in relation to the community or regional need for such capital program or purchase of land, the possible effect on the operating costs of the facility and such other relevant factors as the commissioner or the commissioner's designee deems necessary. In approving or modifying such request, the commissioner or the commissioner's designee may not prescribe any condition, such as, but not limited to, any condition or limitation on the indebtedness of the facility in connection with a bond issued, the principal amount of any bond issued or any other details or particulars related to the financing of

such capital expenditure, not directly related to the scope of such capital program and within the control of the facility. If the hearing is conducted by a designee of the commissioner, the designee shall submit any findings and recommendations to the commissioner. The commissioner shall grant, modify or deny such request within ninety days, except as provided for in this section. Upon the request of the applicant, the review period may be extended for an additional fifteen days if the commissioner or the commissioner's designee has requested additional information subsequent to the commencement of the review period. The commissioner or the commissioner's designee may extend the review period for a maximum of thirty days if the applicant has not filed in a timely manner information deemed necessary by the commissioner or the commissioner's designee.

(d) **[**No**]** Except as provided in this subsection, no facility shall be allowed to close or decrease substantially its total bed capacity until such time as a public hearing has been held in accordance with the provisions of this subsection and the Commissioner of Social Services has approved the facility's request unless such decrease is associated with a census reduction. The commissioner may impose a civil penalty of not more than five thousand dollars on any facility that fails to comply with the provisions of this subsection. Penalty payments received by the commissioner pursuant to this subsection shall be deposited in the special fund established by the department pursuant to subsection (c) of section 17b-357 and used for the purposes specified in said subsection (c). The commissioner or the commissioner's designee shall hold a public hearing upon the earliest occurrence of: (1) Receipt of any letter of intent submitted by a facility to the department, or (2) receipt of any certificate of need application. Such hearing shall be held at the facility for which the letter of intent or certificate of need application was submitted not later than thirty days after the date on which such letter or application was received by the commissioner. The commissioner or the commissioner's designee shall provide both the facility and the public with notice of the date of the hearing not less than fourteen days in advance of such date. Notice to the facility shall be by certified mail and notice to the public shall be by publication in a

newspaper having a substantial circulation in the area served by the facility. The provisions of this subsection shall not apply to any certificate of need approval requested for the relocation of a facility, or a portion of a facility's licensed beds, to a new or replacement facility.

(e) The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this section. The commissioner shall implement the standards and procedures of the Office of Health Care Access division of the Department of Public Health concerning certificates of need established pursuant to section 19a-643, as appropriate for the purposes of this section, until the time final regulations are adopted in accordance with said chapter 54.

Sec. 17. Section 17b-354 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) The Department of Social Services shall not accept or approve any requests for additional nursing home beds, except (1) beds restricted to use by patients with acquired immune deficiency syndrome or by patients requiring neurological rehabilitation; (2) beds associated with a continuing care facility, **[**which guarantees life care for its residents**]** as described in section 17b-520, provided such beds are not used in the Medicaid program. For the purpose of this subsection, beds associated with a continuing care facility are not subject to the certificate of need provisions pursuant to sections 17b-352 and 17b-353, as amended by this act; (3) Medicaid certified beds to be relocated from one licensed nursing facility to another licensed nursing facility to meet a priority need identified in the strategic plan developed pursuant to subsection (c) of section 17b-369; and (4) **[**Medicaid beds to be relocated from a licensed facility or facilities to a new licensed facility, provided at least one currently licensed facility is closed in the transaction, and the new facility bed total is not less than ten per cent lower than the total number of beds relocated. The**]** licensed Medicaid nursing facility beds to be relocated from one or more existing nursing facilities to a new nursing facility, provided (A)

no new Medicaid certified beds are added, (B) at least one currently licensed facility is closed in the transaction as a result of the relocation, (C) the new or relocated facility bed total is no more than ninety per cent of the total number of the licensed beds of the facility from which such beds shall be relocated and no such relocation shall result in an increase in state expenditures, (D) the facility participates in the Money Follows the Person demonstration project pursuant to section 17b-369, (E) the availability of beds in the area of need will not be adversely affected, (F) the certificate of need approval for such new facility or facility relocation and the associated capital expenditures are obtained pursuant to sections 17b-352 and 17b-353, as amended by this act, and (G) the facilities included in the bed relocation and closure shall be in accordance with the strategic plan developed pursuant to subsection (c) of section 17b-369. **[**, provided (A) the availability of beds in an area of need will not be adversely affected; and (B) no such relocation shall result in an increase in state expenditures.

(b) For the purposes of subsection (a) of this section, "a continuing care facility which guarantees life care for its residents" means: (1) A facility which does not participate in the Medicaid program; (2) a facility which establishes its financial stability by submitting to the commissioner documentation which (A) demonstrates in financial statements compiled by certified public accountants that the facility and its direct or indirect owners have (i) on the date of the certificate of need application and for five years preceding such date, net assets or reserves equal to or greater than the projected operating revenues for the facility in its first two years of operation or (ii) assets or other indications of financial stability determined by the commissioner to be sufficient to provide for the financial stability of the facility based on its proposed financial structure and operations, (B) demonstrates in financial statements compiled by certified public accountants that the facility, on the date of the certificate of need application, has a projected debt coverage ratio at ninety-five per cent occupancy of at least one and twenty-five one-hundredths, (C) details the financial operation and projected cash flow of the facility on the date of the certificate of need application, to be updated every five years

thereafter, and demonstrates that fees payable by residents and the assets, income and insurance coverage of residents, in combination with other sources of facility funding, are sufficient to provide for the expenses of life care services for the life of the residents to be made available within a continuum of care which shall include the provision of health services in the independent living units, and (D) provides that any transfer of ownership of the facility to take place within a five-year period from the date of approval of its certificate of need shall be subject to the approval of the Commissioner of Social Services in accordance with the provisions of section 17b-355; (3) a facility which establishes to the satisfaction of the commissioner that it can provide for the expenses of the continuum of care to be made available to residents by complying with the provisions of chapter 319f and demonstrating sufficient assets, income, financial reserves or long-term care insurance to provide for such expenses and maintain financially viable operation of the facility for a thirty-year period based on generally accepted accounting practices and actuarial principles, which demonstration (A) may include making available to prospective residents long-term care insurance policies which are substantially equivalent in value and coverage to policies precertified pursuant to section 38a-475, (B) shall include establishing eligibility criteria and screening each resident prior to admission and annually thereafter to ensure that his assets, income and insurance coverage are sufficient in combination with other sources of facility funding to cover such expenses, (C) shall include entering into contracts with residents concerning monthly or other periodic fees payable by residents for services provided, and (D) allowing residents whose expenses are not covered by insurance to pledge or transfer income, assets or proceeds from the sale of assets in amounts sufficient to cover such expenses; (4) a facility which demonstrates it will establish a contingency fund, prior to becoming operational, in an initial amount of five hundred thousand dollars which shall be increased in equal annual increments to at least one million dollars by the start of the facility's sixth year of operation and which shall be replenished within twelve months of any expenditure, provided the amount to be replenished shall not exceed

two hundred fifty thousand dollars annually until one million dollars is reached, to provide for the expenses of the continuum of care to be made available to residents which may not be covered by residents' assets, income or insurance, provided the commissioner may approve the establishment of a contingency fund in a lesser amount upon the application of a facility for which a lesser amount is appropriate based on the size of the facility; and (5) a facility which is operated by management with demonstrated experience and ability in the operation of similar facilities. Notwithstanding the provisions of this subsection, a facility may be deemed a continuing care facility which guarantees life care for its residents if (A) the facility meets the criteria set forth in subdivisions (2) to (5), inclusive, of this subsection, was Medicaid certified prior to October 1, 1993, and has been deemed qualified to enter into a continuing care contract under chapter 319hh for at least two consecutive years prior to filing its certificate of need application under this section, provided (i) no additional bed approved pursuant to this section shall be Medicaid certified; (ii) no patient in such a bed shall be involuntarily transferred to another bed due to his eligibility for Medicaid and (iii) the facility shall pay the cost of care for a patient in such a bed who is Medicaid eligible and does not wish to be transferred to another bed or (B) the facility is operated exclusively by and for a religious order which is committed to the care and well-being of its members for the duration of their lives and whose members are bound thereto by the profession of permanent vows. On and after July 1, 1997, the Department of Social Services shall give priority to a request for modification of a certificate of need from a continuing care facility which guarantees life care for its residents pursuant to the provisions of this subsection.**]**

[(c)**]** (b) For the purposes of this section and sections 17b-352 and 17b-353, as amended by this act, construction shall be deemed to have begun if the following have occurred and the department has been so notified in writing within the thirty days prior to the date by which construction is to begin: (1) All necessary town, state and federal approvals required to begin construction have been obtained, including all zoning and wetlands approvals; (2) all necessary town

and state permits required to begin construction or site work have been obtained; (3) financing approval, as defined in subsection [(d)] (c) of this section, has been obtained; and (4) construction of a structure approved in the certificate of need has begun. For the purposes of this subsection, commencement of construction of a structure shall include, at a minimum, completion of a foundation. Notwithstanding the provisions of this subsection, upon receipt of an application filed at least thirty days prior to the date by which construction is to begin, the commissioner may deem construction to have begun if: (A) An owner of a certificate of need has fully complied with the provisions of subdivisions (1), (2) and (3) of this subsection; (B) such owner submits clear and convincing evidence that he has complied with the provisions of this subsection sufficiently to demonstrate a high probability that construction shall be completed in time to obtain licensure by the Department of Public Health on or before the date required pursuant to subsection (a) of this section; (C) construction of a structure cannot begin due to unforeseeable circumstances beyond the control of the owner; and (D) at least ten per cent of the approved total capital expenditure or two hundred fifty thousand dollars, whichever is greater, has been expended.

[(d)] (c) For the purposes of subsection [(c)] (b) of this section, subject to the provisions of subsection [(e)] (d) of this section, financing shall be deemed to have been obtained if the owner of the certificate of need receives a commitment letter from a lender indicating an affirmative interest in financing the project subject to reasonable and customary conditions, including a final commitment from the lender's loan committee or other entity responsible for approving loans. If a lender which has issued a commitment letter subsequently refuses to finance the project, the owner shall notify the department in writing within five business days of the receipt of the refusal. The owner shall, if so requested by the department, provide the commissioner with copies of all communications between the owner and the lender concerning the request for financing. The owner shall have one further opportunity to obtain financing which shall be demonstrated by submitting another commitment letter from a lender to the department

within thirty days of the owner's receipt of the refusal from the first lender.

[(e) On and after March 1, 1993, financing**]** (d) Financing shall be deemed to have been obtained for the purposes of this section and sections 17b-352 and 17b-353, as amended by this act, if the owner of the certificate of need has (1) received a final commitment for financing in writing from a lender or (2) provided evidence to the department that the owner has sufficient funds available to construct the project without financing.

[(f) Any decision of the Office of Health Care Access issued prior to July 1, 1993, as to whether construction has begun or financing has been obtained for nursing home beds approved by the office prior to said date shall be deemed to be a decision of the Commissioner of Social Services for the purposes of this section and sections 17b-352 and 17b-353.**]**

[(g)**]** (e) (1) A continuing care facility, **[**which guarantees life care for its residents, as defined in subsection (b) of this**]** as described in section 17b-520, (A) shall arrange for a medical assessment to be conducted by an independent physician or an access agency approved by the Office of Policy and Management and the Department of Social Services as meeting the requirements for such agency as defined by regulations adopted pursuant to subsection (e) of section 17b-342, prior to the admission of any resident to the nursing facility and shall document such assessment in the resident's medical file and (B) may transfer or discharge a resident who has intentionally transferred assets in a sum which will render the resident unable to pay the cost of nursing facility care in accordance with the contract between the resident and the facility.

(2) A continuing care facility, **[**which guarantees life care for its residents, as defined in subsection (b) of this**]** as described in section 17b-520, may, for the seven-year period immediately subsequent to becoming operational, accept nonresidents directly as nursing facility patients on a contractual basis provided any such contract shall

include, but not be limited to, requiring the facility (A) to document that placement of the patient in such facility is medically appropriate; (B) to apply to a potential nonresident patient the financial eligibility criteria applied to a potential resident of the facility; [pursuant to said subsection (b);] and (C) to at least annually screen each nonresident patient to ensure the maintenance of assets, income and insurance sufficient to cover the cost of at least forty-two months of nursing facility care. A facility may transfer or discharge a nonresident patient upon the patient exhausting assets sufficient to pay the costs of his care or upon the facility determining the patient has intentionally transferred assets in a sum which will render the patient unable to pay the costs of a total of forty-two months of nursing facility care from the date of initial admission to the nursing facility. Any such transfer or discharge shall be conducted in accordance with section 19a-535. The commissioner may grant one or more three-year extensions of the period during which a facility may accept nonresident patients, provided the facility is in compliance with the provisions of this section.

[(h) Notwithstanding the provisions of subsection (a) of this section, if an owner of an approved certificate of need for additional nursing home beds has notified the Office of Health Care Access or the Department of Social Services on or before September 30, 1993, of his intention to utilize such beds for a continuing care facility which guarantees life care for its residents in accordance with subsection (b) of this section and has filed documentation with the Department of Social Services on or before September 30, 1994, demonstrating the requirements of said subsection (b) have been met, the certificate of need shall not expire.

(i) The Commissioner of Social Services may waive or modify any requirement of this section, except subdivision (1) of subsection (b) which prohibits participation in the Medicaid program, to enable an established continuing care facility registered pursuant to chapter 319hh prior to September 1, 1991, to add nursing home beds provided the continuing care facility agrees to no longer admit nonresidents into

any of the facility's nursing home beds except for spouses of residents of such facility and provided the addition of nursing home beds will not have an adverse impact on the facility's financial stability, as defined in subsection (b) of this section, and are located within a structure constructed and licensed prior to July 1, 1992.**]**

[(j)**]** (f) The Commissioner of Social Services **[**shall**]** may adopt regulations, in accordance with chapter 54, to implement the provisions of this section. The commissioner shall implement the standards and procedures of the Office of Health Care Access division of the Department of Public Health concerning certificates of need established pursuant to section 19a-643, as appropriate for the purposes of this section, until the time final regulations are adopted in accordance with said chapter 54.

Sec. 18. Subsection (c) of section 19a-654 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(c) An outpatient surgical facility, as defined in section 19a-493b, a short-term acute care general or children's hospital, or a facility that provides outpatient surgical services as part of the outpatient surgery department of a short-term acute care hospital shall submit to the office the data identified in subsection **[**(c)**]** (b) of section 19a-634, as amended by this act. The office shall convene a working group consisting of representatives of outpatient surgical facilities, hospitals and other individuals necessary to develop recommendations that address current obstacles to, and proposed requirements for, patient-identifiable data reporting in the outpatient setting. On or before February 1, 2012, the working group shall report, in accordance with the provisions of section 11-4a, on its findings and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance and real estate. Additional reporting of outpatient data as the office deems necessary shall begin not later than July 1, 2015. On or before July 1, 2012, and annually thereafter, the Connecticut Association of

Ambulatory Surgery Centers shall provide a progress report to the Department of Public Health, until such time as all ambulatory surgery centers are in full compliance with the implementation of systems that allow for the reporting of outpatient data as required by the commissioner. Until such additional reporting requirements take effect on July 1, 2015, the department may work with the Connecticut Association of Ambulatory Surgery Centers and the Connecticut Hospital Association on specific data reporting initiatives provided that no penalties shall be assessed under this chapter or any other provision of law with respect to the failure to submit such data.

Sec. 19. Subsection (b) of section 19a-486b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(b) The commissioner and the Attorney General may place any conditions on the approval of an application that relate to the purposes of sections 19a-486a to 19a-486h, inclusive. In placing any such conditions the commissioner shall follow the guidelines and criteria described in **[**subdivision (4) of**]** subsection **[**(d)**]** (e) of section 19a-639, as amended by this act. Any such conditions may be in addition to any conditions placed by the commissioner pursuant to **[**subdivision (4) of**]** subsection **[**(d)**]** (e) of section 19a-639, as amended by this act.

Sec. 20. Section 17b-59f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) There shall be a State Health Information Technology Advisory Council to advise the Health Information Technology Officer, designated in accordance with section 19a-755, in developing priorities and policy recommendations for advancing the state's health information technology and health information exchange efforts and goals and to advise the Health Information Technology Officer in the development and implementation of the state-wide health information technology plan and standards and the State-wide Health Information Exchange, established pursuant to section 17b-59d. The advisory council shall also advise the Health Information Technology Officer

regarding the development of appropriate governance, oversight and accountability measures to ensure success in achieving the state's health information technology and exchange goals.

(b) The council shall consist of the following members:

(1) The Health Information Technology Officer, appointed in accordance with section 19a-755, or the Health Information Technology Officer's designee;

(2) The Commissioners of Social Services, Mental Health and Addiction Services, Children and Families, Correction, Public Health and Developmental Services, or the commissioners' designees;

(3) The Chief Information Officer of the state, or the Chief Information Officer's designee;

(4) The chief executive officer of the Connecticut Health Insurance Exchange, or the chief executive officer's designee;

(5) The director of the state innovation model initiative program management office, or the director's designee;

(6) The chief information officer of The University of Connecticut Health Center, or said chief information officer's designee;

(7) The Healthcare Advocate, or the Healthcare Advocate's designee;

(8) The Comptroller, or the Comptroller's designee;

[(8)**]** (9) Five members appointed by the Governor, one each of whom shall be (A) a representative of a health system that includes more than one hospital, (B) a representative of the health insurance industry, (C) an expert in health information technology, (D) a health care consumer or consumer advocate, and (E) a current or former employee or trustee of a plan established pursuant to subdivision (5) of subsection (c) of 29 USC 186;

[(9)**]** (10) Three members appointed by the president pro tempore of the Senate, one each who shall be (A) a representative of a federally qualified health center, (B) a provider of behavioral health services, and (C) a representative of the Connecticut State Medical Society;

[(10)**]** (11) Three members appointed by the speaker of the House of Representatives, one each who shall be (A) a technology expert who represents a hospital system, as defined in section 19a-486i, (B) a provider of home health care services, and (C) a health care consumer or a health care consumer advocate;

[(11)**]** (12) One member appointed by the majority leader of the Senate, who shall be a representative of an independent community hospital;

[(12)**]** (13) One member appointed by the majority leader of the House of Representatives, who shall be a physician who provides services in a multispecialty group and who is not employed by a hospital;

[(13)**]** (14) One member appointed by the minority leader of the Senate, who shall be a primary care physician who provides services in a small independent practice;

[(14)**]** (15) One member appointed by the minority leader of the House of Representatives, who shall be an expert in health care analytics and quality analysis;

[(15)**]** (16) The president pro tempore of the Senate, or the president's designee;

[(16)**]** (17) The speaker of the House of Representatives, or the speaker's designee;

[(17)**]** (18) The minority leader of the Senate, or the minority leader's designee; and

[(18)**]** (19) The minority leader of the House of Representatives, or

the minority leader's designee.

(c) Any member appointed or designated under subdivisions **[**(9)**]** (10) to **[**(18)**]** (19), inclusive, of subsection (b) of this section may be a member of the General Assembly.

(d) The Health Information Technology Officer, appointed in accordance with section 19a-755, shall serve as a chairperson of the council. The council shall elect a second chairperson from among its members, who shall not be a state official. The terms of the members shall be coterminous with the terms of the appointing authority for each member and subject to the provisions of section 4-1a. If any vacancy occurs on the council, the appointing authority having the power to make the appointment under the provisions of this section and shall appoint a person in accordance with the provisions of this section. A majority of the members of the council shall constitute a quorum. Members of the council shall serve without compensation, but shall be reimbursed for all reasonable expenses incurred in the performance of their duties.

(e) Prior to submitting any application, proposal, planning document or other request seeking federal grants, matching funds or other federal support for health information technology or health information exchange, the Health Information Technology Officer or the Commissioner of Social Services shall present such application, proposal, document or other request to the council for review and comment.

Sec. 21. Sections 17b-354b and 17b-354c of the general statutes are repealed. (*Effective July 1, 2017*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2018*	New section
Sec. 2	*July 1, 2017*	19a-630
Sec. 3	*July 1, 2017*	19a-634
Sec. 4	*July 1, 2017*	19a-637

Sec. 5	*July 1, 2017*	19a-638
Sec. 6	*July 1, 2017*	19a-639
Sec. 7	*July 1, 2017*	19a-639a
Sec. 8	*July 1, 2017*	19a-639b(e)
Sec. 9	*July 1, 2017*	19a-639c
Sec. 10	*July 1, 2017*	19a-639e
Sec. 11	*July 1, 2017*	19a-639f
Sec. 12	*July 1, 2017*	19a-653
Sec. 13	*July 1, 2017*	19a-486d(a)
Sec. 14	*July 1, 2017*	19a-486i
Sec. 15	*July 1, 2017*	17b-352(a) to (c)
Sec. 16	*July 1, 2017*	17b-353
Sec. 17	*July 1, 2017*	17b-354
Sec. 18	*July 1, 2017*	19a-654(c)
Sec. 19	*July 1, 2017*	19a-486b(b)
Sec. 20	*July 1, 2017*	17b-59f
Sec. 21	*July 1, 2017*	Repealer section

Statement of Legislative Commissioners:
In Section 7(e), the phrase "Except as provided in this subsection, the" was bracketed and "The" was added for accuracy.

PH *Joint Favorable Subst.*

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 18 $	FY 19 $
Public Health, Dept.	GF - Transfer from	None	1,975,432
Healthcare Advocate, Off.	IF - Transfer from	None	3,425,149
Insurance Dept.	IF - Transfer from	None	262,978
Office of Health Strategy (OHS)	GF - Transfer to	None	1,975,432
Office of Health Strategy (OHS)	IF - Transfer to	None	3,688,127
	NET IMPACT	**-**	**-**
Public Health, Dept.	GF - Cost	133,299	144,407
State Comptroller - Fringe Benefits[1]	GF - Cost	50,760	54,990
Resources of the GF	GF - Revenue Gain	184,059	199,397
	NET IMPACT	**-**	**-**

Note: GF=General Fund; IF=Insurance Fund

Municipal Impact: None

Explanation

The bill establishes a new Office of Health Strategy (OHS) and makes changes to the Department of Public Health's (DPH) Office of Health Care Access (OHCA) Certificate of Need (CON) system that implement elements of the Governor's FY 18 and FY 19 Budget. Five positions and associated Insurance Fund support of $3,425,149 for the State Innovation Model Initiative are transferred from the Office of the Healthcare Advocate to OHS in FY 19. One position and associated Insurance Fund support of $262,978 are transferred from the

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 38.08% of payroll in FY 18 and FY 19.

Department of Insurance to OHS in FY 19. Twenty-three positions and associated General Fund support of $1,975,432 for OHCA is transferred to OHS in FY 19. A total of 29 positions and $5,663,559 is transferred to OHS in FY 19.

Two Health Care Analysts are provided to accommodate changes to OHCA's CON system under the bill. Partial year funding in FY 18 reflects an anticipated one month hiring delay. The annualized DPH cost of $144,407 and associated State Comptroller fringe benefits cost of $54,990 will be recouped as General Fund revenue through a hospital assessment. Per CGS Sec. 19a-631 and 632, each hospital annually pays to DPH, for deposit in the General Fund, an amount equal to its share of the actual expenditures made by OHCA during each fiscal year, including the cost of fringe benefits for office personnel as estimated by the Comptroller.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future.

OLR Bill Analysis

sSB 795

AN ACT ESTABLISHING THE OFFICE OF HEALTH STRATEGY AND IMPROVING THE CERTIFICATE OF NEED PROGRAM.

SUMMARY

This bill establishes an Office of Health Strategy within the Department of Public Health (DPH) for administrative purposes only and makes it responsible for, among other things:

1. directing and overseeing the All-Payers Claim Database program, State Innovation Model Initiative, and DPH's Office of Health Care Access (OHCA) and

2. coordinating the state's health information technology initiatives.

The bill also makes various changes to the state's certificate of need (CON) programs administered by OHCA and the Department of Social Services (DSS). Among other changes regarding OHCA, it:

1. eliminates the requirement to obtain a CON for certain activities (such as establishing a mental health or substance abuse treatment facility);

2. creates an expedited review process for certain CON applications;

3. extends provisions on hospital service terminations to also include hospital systems (while allowing for an expedited review in certain circumstances);

4. modifies the factors that OHCA must consider when evaluating a CON application, such as no longer requiring the applicant to show that the proposal will not result in unnecessary duplication

of services;

5. expands the actions OHCA may take when a purchaser breaches a condition of the approval for certain hospital sales; and

6. adds to existing public notice requirements for CON applications.

With respect to DSS, the bill:

1. requires nursing homes, residential care homes, and intermediate care facilities for individuals with intellectual disability (ICF-IIDs) to obtain a CON to relocate any of their licensed beds to a new or replacement facility;

2. exempts from CON requirements nursing homes that are associated with a continuing care facility and do not participate in Medicaid; and

3. modifies exemptions to DSS' moratorium on accepting or approving CONs to add new nursing home beds.

Among other things, this bill also:

1. expands the information that OHCA must include in the statewide health care facilities and services plan, within available appropriations; and

2. adds the comptroller or his designee to the State Health Information Technology Council.

The bill also makes several technical and conforming changes.

EFFECTIVE DATE: July 1, 2017, except that the provisions establishing the Office of Health Strategy take effect July 1, 2018.

§ 1 — OFFICE OF HEALTH STRATEGY

OHS Established

The bill establishes an Office of Health Strategy (OHS), headed by an executive director who serves at the pleasure of the governor. It

places OHS in DPH for administrative purposes only and makes it the successor to the:

1. Connecticut Health Insurance Exchange's responsibilities related to administering the All-Payer Claims Database and

2. Office of the Lieutenant Governor related to (a) consulting with DPH to develop a statewide chronic disease plan; (b) housing, chairing, and staffing the Sustinet Health Care Cabinet; and (c) appointing the state's health information technology officer and overseeing his or her duties.

Any order or regulation of the above entities that is in force on July 1, 2018 continues in force and effect until amended, repealed, or superseded by law. (The bill does not make corresponding changes to remove these responsibilities from the Connecticut Health Insurance Exchange and Office of the Lieutenant Governor statutes.)

Responsibilities

Under the bill, OHS is responsible for:

1. developing and implementing a comprehensive and cohesive health care vision for the state, including a coordinated state health care cost containment strategy;

2. directing and overseeing the All-Payers Claim Database program, State Innovation Model Initiative, and related successor initiatives;

3. coordinating the state's health information technology initiatives;

4. directing and overseeing OHCA and all of its duties and responsibilities; and

5. convening forums and meetings with state government and external stakeholders, including the Connecticut Health Insurance Exchange, to discuss health care issues designed to develop effective health care cost and quality strategies.

§ 2 — DEFINITIONS FOR OHCA LAW

The bill defines several terms for purposes of the OHCA chapter.

For example, it defines "access" as the availability of services to a population that needs the services and the ability to obtain such services when considering the location, reasonable available public or private transportation options, hours of operation, and language of, or cultural considerations for, the population seeking the services.

It defines "health care services" as care and services of a medical, mental health, substance use disorder treatment, surgical, psychiatric, therapeutic, diagnostic, or rehabilitative nature, including inpatient and outpatient acute hospital care and services.

It defines "hospital" as a health care facility or institution licensed by DPH to provide both inpatient and outpatient services as (1) a general hospital (including UConn's John Dempsey Hospital) licensed as a short-term, acute care general or children's hospital or (2) a specialty hospital that provides chronic disease treatment, maternity, inpatient psychiatric, rehabilitation, or hospice services.

The bill removes "central service facility" from the current definition of "health care facility." It refers to "behavioral health facility" within that definition rather than referring separately to "mental health facility" and "substance abuse treatment facility."

Thus, the bill defines "health care facility" to include hospitals; freestanding emergency departments; outpatient surgical facilities; state-operated facilities or institutions that provide services eligible for Medicare or Medicaid reimbursement; behavioral health facilities; and any other facilities requiring CON review by OHCA.

The bill defines "quality" as the degree to which health care services for individuals or populations increase the likelihood of desired health outcomes and are consistent with established professional knowledge, standards, and guidelines.

Certain other definitions are described below in context.

§ 3 — HEALTH CARE FACILITY UTILIZATION STUDY AND FACILITIES AND SERVICES PLAN

Plan Contents

Current law requires OHCA to (1) conduct a biennial statewide health care facility utilization study and (2) establish and maintain a statewide health care facilities and services plan. The bill incorporates the utilization study into the facilities and services plan within available appropriations and specifies that this study must include an assessment of the utilization of several categories of care. By law, OHCA must update the facilities and services plan at least every two years.

The bill requires OHCA, within available appropriations, to include specified information in the facilities and services plan, rather than allowing that information as under current law (such as information on unmet needs of persons at risk and a projection of future demands for services).

It requires the plan to include the following additional information within available appropriations:

1. the identification of geographic areas that may be underserved or have reduced access to specific types of health care services (current law requires this as part of the utilization study);

2. the identification of clinical best practices, as applicable to CON requirements; and

3. recommendations for (a) addressing identified unmet health care needs, (b) integrating and aligning clinical best practices into licensure requirements or other ongoing DPH monitoring efforts to enhance quality of care, and (c) any improvements or changes necessary to OHCA's programs, including the CON process, to promote health equity.

It eliminates a provision that allowed the plan to include

recommendations for expanding, reducing, or modifying health care facilities or services.

Incorporating the Plan into Facility Long-Range Planning

Current law requires the DPH commissioner, in consultation with hospital representatives, to develop a process that encourages hospitals to incorporate the facilities and services plan into their long-range planning. The bill extends this consultation process and related provisions to hospital systems and other health care facilities.

Inventory and Questionnaire

Under current law, OHCA must establish and maintain an inventory of health care facilities and specified equipment, to use in preparing the utilization study and facilities and services plan. The bill continues to require the inventory for purposes of the plan.

The bill allows OHCA to use a questionnaire to obtain specified information for the inventory, rather than requiring OHCA to develop the questionnaire. It requires facilities and providers to complete the inventory every three years, rather than every two years.

§ 4 — OHCA PROMOTION OF QUALITY SERVICES

Existing law requires OHCA to promote the provision of quality health care services to ensure that all state residents have access to cost effective services. The bill eliminates a requirement for OHCA to promote such services in a manner that avoids duplication of services.

§§ 5 & 10 — ACTIVITIES OR TRANSACTIONS REQUIRING OHCA CON APPROVAL

Generally, current law requires a health care facility to obtain a CON from OHCA when proposing to (1) establish a new facility or provide certain new services, (2) change ownership, (3) purchase or acquire certain equipment, or (4) terminate certain services. In some circumstances, a facility must request a determination from OHCA as to whether a CON is required.

The bill makes various changes to when CON approval is required,

as follows.

Establishment of New Facilities (§§ 5(a)(1) & 10(c))

The bill eliminates the requirement to obtain a CON to establish a central service facility, mental health facility, or substance abuse treatment facility. It continues to require CON approval to establish a new hospital, freestanding emergency department, or outpatient surgical facility, but creates an exception to the standard CON process if the facility will be in an area identified in the statewide health care facilities and services plan as underserved or having reduced access to specific types of health care services.

In such a case, the person proposing to establish the facility must submit a determination request to OHCA no later than 60 days before the facility's proposed establishment. The request must include the proposed date when the facility will be operational and demonstrate that (1) the new facility will be located in an area that has been identified in the statewide plan as being underserved or having reduced access to specific types of health care services and (2) Medicaid recipients and indigent people will have access to the services provided.

Under the bill, if these standards are not met, the requester must file a standard CON application. The bill allows OHCA to ask for additional information from the person as necessary to process the request.

Service Terminations (§§ 5 & 10(a), (d))

Current law generally requires a CON to terminate inpatient or outpatient services offered by (1) a hospital or (2) a state-operated facility or institution that provides services eligible for Medicare or Medicaid reimbursement. The bill extends this requirement to hospital systems. It specifies that terminations do not include temporary suspensions of services lasting six months or less (see § 2 (26) of the bill). It also creates an exception from the standard CON procedure for service terminations due to insufficient patient volume or lack of

available practitioners to support the effective delivery of care, subject to OHCA approval.

Determination Requests. Under the bill, any hospital or hospital system proposing to terminate or reduce services (see below) for the above reasons must submit a determination request to OHCA not later than 60 days before the proposed termination or reduction date. The request must include:

1. the date of the proposed termination or reduction;

2. documentation that the hospital or hospital system is experiencing insufficient patient volume or lack of practitioners for the service, resulting in its inability to support effective delivery of care; and

3. whether the service termination or reduction will occur in an area that has been identified in the statewide health care facilities and services plan as being underserved or having reduced access to specific types of health care services.

If the hospital or hospital system is unable to demonstrate to OHCA's satisfaction that the proposed termination or reduction is due to insufficient patient volume or the lack of practitioners to support the effective delivery of care, it must file a standard CON application. OHCA may request additional information as necessary to process the request. (It is unclear whether such service reductions require CON approval, because the bill does not make corresponding changes to the statute listing the activities that require CON approval.)

The bill defines "reduction" as any modification to a health care service by a hospital or hospital system that, independently or in combination with other changes, results in a 50% or greater decrease in the availability of the health care service offered by the hospital or hospital system, or reduces the service area covered by the hospital or hospital system.

Modification Requests. The bill eliminates the current requirement

that health care facilities file a modification request with OHCA if seeking to terminate a service that was authorized by a CON but does not require a CON for its termination. The bill also eliminates a requirement that OHCA hold a public hearing on such requests in certain circumstances.

Notification for Terminations Not Requiring a CON. Under current law, if a facility proposes to stop operating or terminate a service for which a CON was not originally obtained and a CON is not required for the termination, the facility must notify OHCA at least 60 days before taking such action. Such notice is also required if a facility proposes to terminate all services that were authorized by a CON and a CON is not required for the termination.

The bill instead requires this notice for facility or service terminations that do not need CON approval, regardless of whether a CON was originally obtained. The notice must include:

1. the facility's name and location,
2. the reason for the termination,
3. other locations where patients may be able to obtain the services the facility provides, and
4. the termination date.

Other Exceptions. Similar to current law, the bill provides that a CON is not required to terminate services for which DPH has requested a hospital to relinquish its license. The bill eliminates the current requirement for CON approval for certain terminations of surgical services by outpatient surgical facilities. Such terminations are subject to the notice requirement described above.

Scanners and Other Technology (§§ 5 & 10)

Current law generally requires a CON for the acquisition of various imaging scanners, including CT, MRI, PET, and PET-CT scanners. Among other exceptions, a CON is not required to replace a scanner

that was previously acquired through CON approval.

The bill specifies that the above list of scanners is not exhaustive, and adds to the list single-photon emission computed tomography. It also provides that standard CON approval for any such scanner is only required if the person or entity filed a determination request with OHCA and did not sufficiently demonstrate to OHCA's satisfaction that (1) the person or entity will minimize the practice of patient referrals in which the referring provider stands to financially gain from the referral and (2) Medicaid recipients and indigent people will have access to the services provided using the equipment.

Determination Requests. Under the bill, anyone proposing to acquire such scanners (except for certain replacements described below) must submit a determination request to OHCA no later than 60 days before the proposed acquisition date. The request must (1) indicate the proposed acquisition date, (2) demonstrate that the above patient access and referral standards will be met, and (3) indicate whether the equipment will be used in an area that has been identified in the statewide plan as being underserved or having reduced access to specific types of services.

If the above standards are not met, then the person or entity must file a CON application. The bill allows OHCA to ask for additional information from the person or entity as necessary to process the request.

Under the bill, if the proposal is to replace an existing scanner with a similar scanner and the existing scanner was acquired through a CON approval or determination, then the person or entity is not required to submit a determination request, but must notify OHCA of the replacement date and the disposition of the replaced scanner.

Other Specified Technology. The bill also eliminates the current requirement to obtain a CON to acquire (1) equipment utilizing technology that has not been previously used in the state and (2) nonhospital linear accelerators (devices used for radiation therapy for

cancer).

Increases in Bed Capacity or Operating Rooms (§ 5)

The bill eliminates the requirement to obtain a CON for:

1. an increase in a health care facility's licensed bed capacity or

2. an increase of two or more operating rooms within any three-year period by an outpatient surgical facility or a short-term acute care general hospital.

§§ 5(C) & 9 — FACILITY RELOCATIONS

Under current law, a health care facility proposing to relocate must send a letter to OHCA describing the project and asking the office to determine if a CON is required. If the facility demonstrates to OHCA's satisfaction that the population the facility serves and the payer mix will not substantially change due to the relocation, then a CON is not required.

The bill makes a technical change by referring to this document as a "determination request" rather than a "letter."

§ 6 — CON GUIDELINES AND CRITERIA

By law, when considering a CON application, OHCA must consider and make written findings concerning specified principles and guidelines. The factors are currently the same for all types of CON applications, except certain additional factors apply to applications seeking to transfer ownership of a hospital.

The bill makes several changes to these provisions. Instead of applying the same factors to all CON applications as is generally the case under current law, it specifies factors for different types of CON applications. It also modifies some of the existing factors, eliminates certain factors, and adds new ones.

For example, the bill eliminates current requirements that OHCA consider whether:

1. there is a clear public need for the proposed facility or services and the population to be served has a need for the proposed services,

2. the applicant has shown that the proposal will not result in unnecessary duplication of services or facilities, and

3. the applicant has shown how the proposal will impact the financial strength of the state's health care system.

Tables 1 through 3 list the factors that OHCA must consider under the bill when evaluating a standard CON application. The bill specifies that OHCA must consider these guidelines and principles as applicable. The bill also removes a provision that allows OHCA, as it deems necessary, to revise or supplement the guidelines and principles through regulation.

Table 1 lists the bill's guidelines for CON applications to:

1. establish a new hospital, freestanding emergency department, or outpatient surgical facility;

2. transfer ownership of health care facilities;

3. transfer ownership of a large group practice to any entity other than a (a) physician or (b) group of physicians not affiliated with a hospital or certain other entities;

4. establish cardiac services; or

5. acquire scanners that use imaging techniques.

Table 1: Guidelines for OHCA Consideration of CON Applications for Establishing New Facilities; Transferring Ownership of Certain Facilities; Establishing Cardiac Services; or Acquiring Scanners

Guidelines Under the Bill
Whether the proposal is consistent with any applicable policies and standards adopted in DPH regulations

Whether the proposal is aligned with the statewide health care facilities and services plan, including whether the proposal will serve individuals in underserved areas or areas with reduced access to specific types of health care services
Whether the applicant has satisfactorily demonstrated that the proposal will not adversely impact the health care market in the state; will improve the quality, accessibility, and cost-effectiveness of health care delivery in the region; and, regarding the acquisition of scanners, will minimize patient referrals in which the referring practitioner will gain financially from the referral
The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including whether the applicant has satisfactorily demonstrated how the proposal will provide access to services by Medicaid recipients and indigent people
Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact patient choice of providers in the region

Table 2 lists the bill's guidelines for CON applications to terminate an emergency department or inpatient or outpatient services offered by a hospital, hospital system, or other state-operated facility or institution that provides services eligible for Medicare or Medicaid reimbursement.

Table 2: Guidelines for OHCA Consideration of CON Applications for Terminating Specified Services

Guidelines Under the Bill
Whether the proposal is consistent with any applicable policies and standards in DPH regulations
Whether the proposal is aligned with the statewide health care facilities and services plan, including whether the proposal will affect individuals in underserved areas or areas with reduced access to specific types of health care services
Whether the applicant has satisfactorily demonstrated that the proposal will not adversely impact the quality, accessibility, and cost effectiveness of health care delivery in the region
The applicant's past provision of health care services to relevant patient populations and payer mix, including whether the applicant has satisfactorily demonstrated how the proposal will not adversely impact access to services by Medicaid recipients and indigent people
Whether the applicant has satisfactorily identified the population that currently utilizes a service proposed for termination, reduction, or relocation and satisfactorily demonstrated that the identified population has access to alternative locations to obtain such services (It is unclear how this provision applies to service reductions or relocations)
The utilization of existing health care facilities and services in the applicant's service area

Whether the applicant has demonstrated good cause for a proposed termination, reduction, or relocation that (1) will result in reduced access to services by Medicaid recipients or indigent people or (2) is located in an underserved area or area with reduced access to specific services (good cause may not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other payers) (It is unclear how this provision applies to service reductions or relocations)
Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact patient choice of providers in the region

Table 3 lists the bill's guidelines for CON applications to transfer ownership of a hospital to another hospital, hospital system, or other entity.

Table 3: Guidelines for OHCA Consideration of CON Application to Transfer Ownership of Hospitals

Guidelines Under the Bill
Whether the applicant fairly considered alternative proposals or offers in light of maintaining provider diversity and consumer choice and access to affordable quality care for the affected community
Whether the applicant's service delivery plan shows, in a manner consistent with the OHCA statutes, how the new hospital will provide health care services for the first three years after the ownership transfer, including any new services or consolidation, reduction, elimination, or expansion of existing services
Whether the proposal is aligned with the statewide health care facilities and services plan, including whether the proposal will serve individuals in areas that are underserved or have reduced access to specific types of health care services
Whether the applicant has satisfactorily demonstrated that the proposal will improve the quality, accessibility, and cost effectiveness of health care delivery in the region and that any consolidation will not adversely affect health care costs or care accessibility
The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including whether the applicant has satisfactorily demonstrated how the proposal will not adversely impact access to services by Medicaid recipients and indigent people
Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the patient choice of providers in the region

§ 6(G) — POST-TRANSFER COMPLIANCE REPORTER; BREACH OF CONDITIONS

Under current law, if OHCA approves a CON for certain hospital ownership transfers, it must hire an independent consultant to serve as a post-transfer compliance reporter for three years following

completion of the transfer. This applies if the purchaser is a hospital or a hospital system that (1) had net patient revenue exceeding $1.5 billion for FY 13 or (2) is organized or operated for profit.

The bill provides that the compliance reporter must have no previous financial interest with the hospital or hospital system, or any of their affiliates; no previous sanctions; and no adverse decisions regarding monitoring activities.

Under current law, the purchaser must pay the cost of hiring the reporter in an amount OHCA determines, up to $200,000 annually. The bill instead requires the purchaser, upon filing the CON application, to establish an escrow account pursuant to a formal escrow agreement provided by OHCA for the purpose of paying for the reporter's services. The purchaser must initially fund the escrow account with $200,000. The escrow agent must pay the bills for the reporter's services out of the escrow account, directly to the reporter, no later than 30 days after the purchaser receives the bill.

Under existing law, if the reporter finds that the purchaser breached a condition of the CON approval, OHCA may implement a performance improvement plan. The bill also allows OHCA to:

1. bring an action to enjoin the purchaser from violating the CON;

2. impose a civil penalty (see § 12); and

3. for a breach of conditions on cost or price limits, require partial or full refunding or repayment of the excess amount to the affected payer.

§ 6(H) — CONDITIONS ON CON APPROVAL

Subject to certain procedures, existing law allows OHCA to place conditions on its approval of a CON application involving a hospital ownership transfer. The bill extends these provisions to approvals of any CON application.

§§ 5, 6 & 8-10 — CON REGULATIONS

The bill allows the DPH commissioner to adopt regulations to implement the provisions on CON guidelines and related matters; the independent consultant; and conditions on CON approval and a breach of those conditions (§ 6(i)).

The bill also eliminates past deadlines for the DPH commissioner to adopt regulations on various matters related to the CON law.

§ 7 — CON APPLICATION PROCEDURES

Notice of CON Application (§ 7(b) and (d))

Existing law requires a CON applicant to publish notice of its application in a newspaper with substantial circulation in the project's area for three consecutive days, no more than 20 days before submitting the application. The bill additionally requires the applicant, within this same time frame, to request the publication of notice (1) in at least two sites in the affected community that are commonly accessed by the public (such as a town hall or library) and (2) on the town's or local health department's existing website, if any.

Existing law requires OHCA to post notice on its website when it determines that a CON application is complete. The bill requires OHCA to provide the link to the completed application to any entity that published notice of the application as described above, for publication of the application.

Additional Information Required for Certain Applications (§ 7(g))

For CON applications involving a hospital ownership transfer, the bill requires the applicant to include in a single application all information related to supplemental transactions associated with the transfer that would otherwise require a separate CON application. The bill specifies that any such application is subject to a cost and market impact review (CMIR). (Existing law, unchanged by the bill, only requires a CMIR for hospital ownership transfers to sellers meeting certain criteria (see (§ 11).)

Public Hearings (§ 7(f))

Existing law requires OHCA to hold a public hearing on a CON application in certain circumstances; in other circumstances, OHCA may hold a public hearing.

The bill increases, from two to three weeks, the advance written notice that OHCA must provide to the applicant before the hearing. It requires the applicant, rather than OHCA as under current law, to provide two weeks' public notice in a newspaper having substantial circulation in the area to be served. It also requires the applicant to provide notice of the hearing by requesting publication in at least two sites within the affected community that are commonly accessed by the public and on the town's or local health department's existing website, if any.

Independent Consultant (§ 7(h))

The bill allows OHCA to retain an independent consultant with expertise in the specific area of health care that is the subject of a pending CON application if OHCA cannot reasonably review the application without the expertise of an industry analyst or other actuarial consultant.

Under the bill, if OHCA determines that it must retain a consultant, the applicant must establish an escrow account pursuant to a formal escrow agreement provided by OHCA for the purpose of paying the consultant. The applicant must initially fund the account in an amount OHCA determines, up to $20,000.

OHCA must submit bills for the consultant's services to the applicant, up to a maximum of $20,000 per application. The escrow agent must pay these bills out of the escrow account directly to the consultant no later than 30 days after the applicant receives the bill.

The bill specifies that any such agreement is not subject to the law's provisions on the Department of Administrative Services' personal services agreements and methods for awarding contracts by state contracting agencies.

§ 11 — COST AND MARKET IMPACT REVIEW

Consultant's Bills (§ 11(k))

Existing law requires OHCA, through an independent consultant, to conduct a cost and market impact review (CMIR) of CON applications that propose to transfer a hospital's ownership if the purchaser is (1) a hospital or a hospital system that had more than $1.5 billion in net patient revenue in FY 13 or (2) organized or operated for profit. The CMIR considers factors related to the transacting parties' businesses and relative market positions. In certain circumstances, OHCA must refer its final CMIR report to the attorney general for investigation.

Under existing law, the purchaser must pay for the services of the CMIR consultant, up to $200,000 per application. The bill requires the purchaser, upon filing the CON application, to establish an escrow account pursuant to a formal escrow agreement provided by OHCA for the purpose of paying the consultant. The applicant must initially fund the escrow account with $200,000. The escrow agent must pay the consultant's bills out of the escrow account directly to the consultant not later than 30 days after the purchaser receives the bill.

Definitions (§ 11(a), (m))

The bill eliminates the current requirement that the DPH commissioner adopt regulations defining several terms concerning the CMIR provisions. The bill instead defines these terms as follows.

The bill defines "dispersed service area" as a geographic area in which a provider organization delivers health care services (1) based on the number of zip codes, towns, counties, or primary service areas in the geographic area and (2) the standards of which may vary based upon the area's population density compared to other regions of the state.

"Health status adjusted total medical expense" is a measure of the total cost of care, adjusted by health status, for the patient population associated with a provider group, which may be (1) calculated based on allowed claims for all categories of medical expenses and all non-claims-related payments to providers and (2) expressed on a per member per month basis.

"Major service category" is a set of categories that may include (1) acute hospital inpatient services, by Medicare Severity-Diagnosis Related Groups; (2) outpatient and ambulatory services, by categories as defined by the federal Centers for Medicare and Medicaid Services (CMS); and (3) behavioral, substance use disorder, and mental health services, by CMS-defined categories.

"Relative prices" means a measure that (1) compares amounts paid to a provider relative to other providers for the same services and (2) may be calculated based on the contractually negotiated amounts paid by each private and public health carrier, including non-claims-related payments, and expressed in the aggregate relative to the payer's network-wide average amount paid to providers.

"Total health care spending" is a measure of all health care expenditures in the state from public and private sources, including (1) all categories of medical expenses and all non-claims-related payments to providers; (2) all patient cost-sharing amounts, deductibles, and copayments; and (3) the net cost of private health insurance, which may be expressed as an annual per capita sum.

§ 12 — CON PENALTIES

Under the bill, any person, facility, or institution required to file a CON with OHCA that negligently fails to seek a CON approval or to file information within prescribed time periods, is subject to a civil penalty of up to $1,000 a day for each day activities are conducted without a CON or information is delayed.

Current law imposes this penalty on people or entities who willfully commit these actions.

The bill also extends the civil penalty to people or entities who fail to comply with any condition OHCA places on a CON application. The penalty applies for each day the condition is breached.

§ 13 — ESCROW ACCOUNTS FOR EXPERTS ASSISTING WITH CON REVIEW

Current law allows the DPH commissioner to (1) contract with experts or consultants to help review a CON application that proposes to transfer a nonprofit hospital to a for-profit purchaser and (2) bill the purchaser up to $150,000 for these experts' services.

The bill requires the purchaser, when filing the CON application with DPH and the attorney general, to establish an escrow account to pay bills the DPH commissioner submits for the experts' services. DPH must provide the purchaser with a formal escrow agreement, and the purchaser must initially fund the escrow account with $150,000.

Under the bill, the escrow agent must pay the bills directly to the expert or consultant out of the escrow account within 30 days after receiving each bill. Current law requires the purchaser to pay these bills within the same time frame.

§ 14 — ANNUAL REPORTING FOR HOSPITALS AND CERTAIN GROUP PRACTICES

The bill extends, from December 31, 2014 to January 15, 2018, the date by which (1) hospitals and hospital systems with affiliated group practices and (2) unaffiliated group practices of 30 or more physicians must start annually reporting information about the group practices to the attorney general and DPH commissioner. The law specifies information the report must include, such as (1) the name and specialty of each physician practicing within the group practice and (2) a description of services at each location.

The bill also extends, from December 31, 2015 to January 15, 2018, the date by which hospitals and hospital systems must start annually filing written reports with the attorney general and DPH commissioner describing their affiliation with any other hospital or hospital system.

To conform to current DPH practice, the bill limits the above reporting requirements to short-term acute care general hospitals and children's hospitals, including UConn's John Dempsey Hospital.

§§ 15 & 16 — DSS CERTIFICATE OF NEED

Bed Relocations

The bill requires nursing homes, residential care homes, and intermediate care facilities for individuals with intellectual disability (hereinafter, "facilities") to obtain a CON from the Department of Social Services (DSS) before relocating any of their licensed beds to a new or replacement facility. It specifies that the department is not required to hold a public hearing on these CON applications, as it must currently do for applications proposing to terminate or significantly reduce a facility's total bed capacity.

Existing law, unchanged by the bill, requires these facilities to obtain a CON when (1) transferring ownership before initial licensure, (2) adding or expanding functions or services, (3) terminating or substantially decreasing their total bed capacity, and (4) making certain capital improvements. (These facilities are exempt from DPH's CON requirements for health care facilities.)

Capital Expenditures

The bill eliminates the requirement that facilities obtain a CON from both DPH and DSS when acquiring major medical equipment that requires a capital expenditure over $400,000.

Existing law also requires facilities to obtain a CON from DSS for capital expenditures exceeding (1) $1 million that increase the facility's square footage by the greater of 5% or 5,000 square feet or (2) $2 million.

Exemption

The bill exempts from DSS' CON requirements nursing homes that are associated with a continuing care facility (i.e., continuing care retirement facility) and do not participate in Medicaid.

The bill also makes related technical and conforming changes.

§ 17 — NURSING HOME BED MORATORIUM

Exemptions

The bill modifies exemptions to DSS' moratorium on accepting or

approving CONs to add new nursing home beds. Current law exempts from the moratorium Medicaid beds relocated from one licensed facility to another provided at least one facility is closed in the transaction and the new facility's bed total is at least 10% lower than the number of relocated beds. The bill instead exempts Medicaid beds relocated from one nursing facility to a new nursing facility if:

1. no new Medicaid-certified beds are added;

2. at least one licensed facility is closed in the transaction as a result of the relocation;

3. the new or relocated facility bed total is no more than 90% of the total licensed beds of the facility relocating them;

4. the facility participates in the federal Money Follows the Person demonstration program; and

5. a CON is obtained for the new facility or facility relocation and associated capital expenditures.

As under current law, the relocation cannot increase state expenditures or adversely affect bed availability in the area of need. However, the bill removes this requirement for the relocation of Medicaid certified beds relocated from one licensed nursing facility to another to meet a priority need identified in the state's strategic plan to rebalance long-term care services and supports.

The bill also deletes obsolete provisions on continuing care facilities and CON.

Regulations

The bill allows, rather than requires, the DSS commissioner to adopt CON regulations.

§§ 18 & 19 — TECHNICAL AND CONFORMING CHANGES

The bill makes technical and conforming changes related to sections 3 and 6.

§ 20 — STATE HEALTH INFORMATION TECHNOLOGY ADVISORY COUNCIL

The bill adds the comptroller or his designee to the State Health Information Technology Council, increasing the council's membership to 32.

§ 21 — REPEALER

The bill repeals (1) a provision allowing the DSS commissioner to approve Medicaid bed relocations from a nursing home to a continuing care facility, if the relocation meets certain criteria (CGS §17b-354b) and (2) an obsolete provision allowing certain nursing homes to convert beds from an intermediate to a nursing level of care under certain conditions (CGS § 17b-354c).

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 16 Nay 10 (03/27/2017)